

Cardiology

Management of Acute Myocardial Infarction*

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The syndrome of myocardial infarction is the most serious and spectacular manifestation of arteriosclerotic heart disease. In common clinical parlance, attacks are often called "coronary thrombosis," "coronary occlusion," or "myocardial infarction." The latter term signifies necrosis of a portion of heart muscle due to interruption or curtailment of its blood supply. It is usually caused by acute coronary thrombosis but it should be remembered that "myocardial infarction" and "coronary thrombosis" are not synonymous. In the presence of good collateral circulation, coronary thrombosis may fail to produce infarction, and infarction, on the other hand, may occur in the absence of an occlusive arterial lesion. In this latter circumstance, the infarction is due to some factor other than coronary obstruction (e.g. hemorrhage, anemia, shock) which results in prolonged anoxia of the myocardium. Although in a given infarction it is usually impossible to say whether or not coronary thrombosis is present, it is nevertheless important to clearly distinguish between the two terms. Coronary thrombosis without infarction results in a prolonged attack of cardiac ischemic pain which is not followed by fever, leucocytosis, elevated sedimentation rate, or electrocardiographic changes of infarction. Sometimes it takes the form of sudden onset of rapidly progressive angina of effort, or a sudden intensification of a previously existing angina of effort. Prodromal symptoms of this kind are common preceding infarction; the therapeutic importance of recognizing this symptom-pattern will be discussed later. On the other hand, in coronary thrombosis with infarction it is the infarction and not the thrombosis which produces the shock, prolonged pain, acute left ventricular failure, fever, leucocytosis, increased sedimentation rate, and characteristic electrocardiographic changes. (Figs. 1 and 2) (Mounted after Wood¹).

"Coronary occlusion" denotes sudden obstruction of a coronary artery and includes coronary thrombosis. However, it also includes obstruction due to other causes such as coronary embolism, subintimal hemorrhage, and obstruction of coronary ostia.

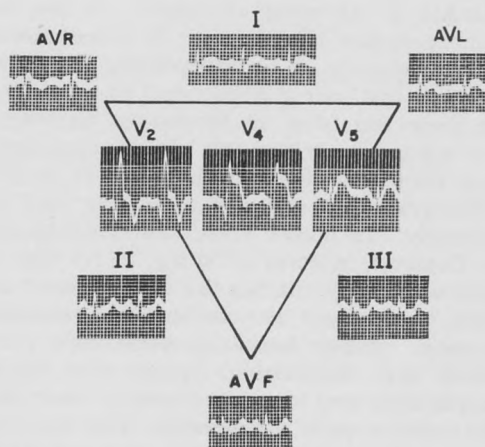


FIG. 1

Recent anterior myocardial infarction. Note the elevation of ST segments in Leads I - aVL - V₂ - V₄ - V₅ and the deep Q waves in V₂ and V₄.

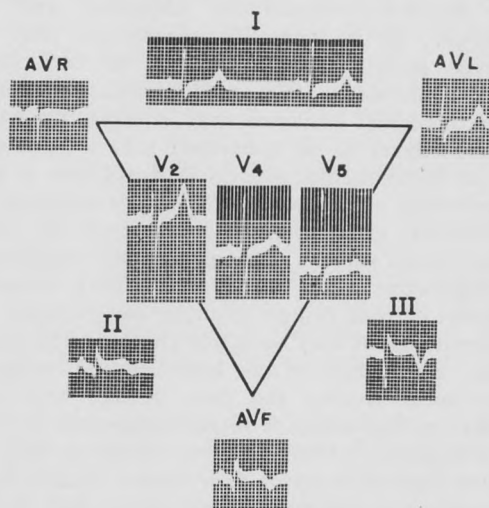


FIG. 2

Recent posterior myocardial infarction. Note the elevation of ST segments, T wave inversion, and Q waves in Leads II - III and aVF.

Treatment—General Measures

Experience with myocardial infarction has been substantial enough for general therapeutic procedures to have become established. There is

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general agreement on the objectives to be achieved, but there are considerable differences of opinion as to the details of treatment. In this discussion only treatments of proven value will be recommended but it is admitted that in a field where it is difficult to secure reliable statistics, it is imprudent to be too dogmatic. Assuming that the diagnosis of myocardial infarction has been established, the following measures are advocated:

(1) **Relief of Pain**—Early and adequate relief of pain is a prime requisite; not only does it relieve suffering and allay apprehension, but it aids in the prevention of shock. Morphine or one of its substitutes is the drug of choice. It has been customary to give morphine gr. $\frac{1}{4}$ subcutaneously or intramuscularly at once, repeating the dose in one-half to one hour if necessary. In more recent years there has been an increasing tendency to give it intravenously and this is to be commended. A good plan is to give half the dose (gr. $\frac{1}{8}$ to gr. $\frac{1}{6}$) intravenously and the remaining half subcutaneously. In milder cases, the synthetic analgesic, Demerol, in doses of 50 mg. to 100 mg., acts equally effectively. It has the advantage of causing less nausea, and less cerebral and respiratory depression. Other measures sometimes recommended are intravenous papaverine and/or aminophylline and oxygen therapy; their value in the relief of pain is debatable. Ordinary vasodilators such as nitroglycerine and the nitrites are ineffective and may be detrimental.

(2) **Rest**—Adequate bed-rest is still the cornerstone of treatment, but its proper utilization requires considerable judgment and experience. It is generally considered that the average patient should be put to bed for a period of six weeks. This recommendation is based on pathological evidence that it takes six weeks for an infarct to be converted into a firm scar, and on experimental studies showing that at least three weeks are necessary for the development of a collateral circulation to supplement the interrupted blood supply. This prescribed period must be lengthened when infarction has been extensive or when cardiac failure or other complication has occurred, and it may be safely shortened in milder cases. Since most of the fatalities and complications occur during the first, second and third weeks, in that order, it seems reasonable to insist on a minimum of two to three weeks in bed, and then a further three or four weeks during which the patient spends most of his time in bed. During the period of stricter bed-rest, activity in bed is also graded according to the condition of the patient. Very ill patients with tachycardia and low blood pressure may have to be fed and kept very still but patients who can move their arms and legs without producing symptoms or signs ought to be allowed to do so. Undue restriction of activity may result in hypostatic pneumonia or

venous thrombosis with consequent pulmonary embolism. Clinical observation of the patient's condition may be helpfully supplemented by serial determinations of the sedimentation rate.

In recent years it has become generally acknowledged that use of a bed pan often involves more physical exertion than the use of a commode at the bedside. As soon as the patient is strong enough to make the short move, with the assistance of nurses or orderlies, he should be permitted the privilege.

Mental and emotional rest are also of considerable importance. This can be achieved by isolating the patient from outside communications and contacts which may disturb him, by frequent reassuring but confident reassurance that he will get well, and by sufficient mild sedation to ensure relaxation by day and restful sleep at night. Phenobarbital, in doses of one-half grain three times a day, or sodium amytal, one grain two to four times a day, are useful for this purpose.

(3) **Treatment of Shock**—From 15 to 20 per cent of patients with myocardial infarction exhibit a shock-like state which carries a mortality of 50 to 90 per cent.² Unfortunately, there is no satisfactory specific treatment. Therapeutic measures ordinarily employed in other forms of shock are dangerous in that they may overload the circulation or strain the injured myocardium. Early alleviation of pain and anxiety coupled with complete bed-rest are indirectly helpful, but in the absence of these measures, fatal shock may ensue in patients who have no pulmonary edema and who do not exhibit venous engorgement, small transfusions of blood or plasma, given very slowly, have been tried. This therapy is still under investigation and preliminary reports³ reveal no convincing benefit. Some means to prevent or relieve this complication of infarction is one of the most needed treatment measures in the disease.

Figure 3 illustrates improvement in blood pressure following intravenous plasma. This 72-year-old man, suffering from angina pectoris, was examined on July 5, 1950, at which time his blood pressure was 135/85. On July 16, 1950, he suffered a sudden severe retrosternal pain which was followed by collapse. His doctor was unable to obtain a blood pressure reading by the auscultatory method during the next twelve hours. The following day, July 17, he was seen in consultation by one of us; his systolic blood pressure, obtained by palpation only, was 75 mm. He was given transfusions of 300 cc. of plasma following which his systolic pressure rose to 90 mm. He was then transferred forty miles by ambulance to hospital where diagnosis of extensive myocardial infarction was confirmed. He was given heparin and Dicumarol, successfully treated for congestive heart failure and bronchopneumonia, and then, when

appeared that he was going to recover, he died suddenly. Death was presumably due to myocardial rupture but necropsy was not performed.

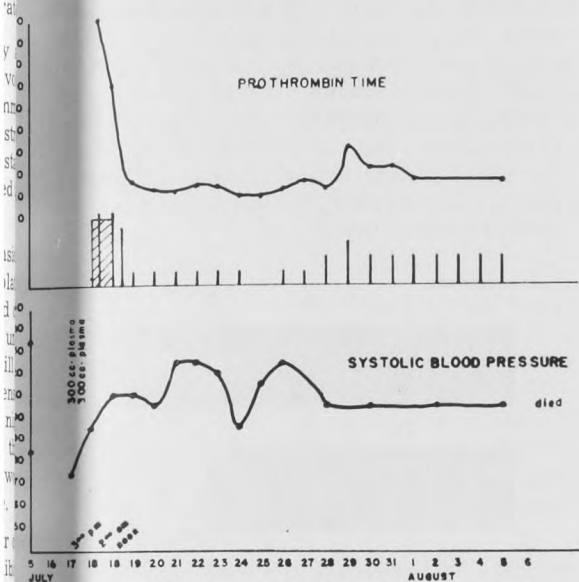


FIG. 3

Use of intravenous plasma in treatment of shock following myocardial infarction.

(4) **Oxygen**—In myocardial infarction, as elsewhere, the clearest clinical indication for oxygen therapy is cyanosis. But it must be remembered that slight degrees of cyanosis are easily overlooked, especially in shocked patients where it may be manifested as a grayish or ashen hue. The role of oxygen has been succinctly summarized by Friedberg: "In practice it has been my custom to give oxygen therapy a trial in all cases in which there is severe or persistent pain, dyspnea, cardiac asthma, pulmonary edema, Cheyne-Stokes respiration and, of course, cyanosis. This therapy is continued if there is any evidence of objective or subjective improvement of the symptom for which it was administered. As the patient improves and the oxygen is discontinued, it is promptly resumed if there is evidence that the patient was more comfortable during its administration or if objective signs reappear which had been abolished by the oxygen."

(5) **Treatment of Complications**—Detailed discussion of the treatment of the many complications of myocardial infarction is beyond the scope of this paper. Persistent congestive heart failure not uncommonly occurs and should be treated with digitalis and other standard measures ordinarily used in the management of cardiac failure. Moderately rapid oral administration of digitalis leaf is probably less hazardous than the use of massive single doses of digitalis glucosides. Auricular fibrillation following myocardial infarction usually subsides spontaneously within a few hours and

does not require treatment. If persistent, however, quinidine may be given. For the dangerous rhythm of ventricular tachycardia, quinidine or Pronestyl is indicated.

Results of Standard Treatment

From a study of the literature it is difficult to decide what the mortality rate has been in cases not specifically treated. Figures must exclude cases of sudden death and refer only to those which survive long enough to receive medical care.

TABLE I
Results of Standard Treatment
I — The Mortality
(during first few weeks)

AUTHOR	No. of Mortality		REMARKS
	Cases	%	
Levine and Brown (1928) ⁶	145	53	
Connor and Holt (1930) ⁷	284	16	First attacks only
Harrington and Wright (1933) ⁸	148	54	
Master et al (1936) ⁹	267	17	
Levine and Rosenbaum (1941) ¹⁰	208	33	
Woods and Barnes (1941) ¹¹	128	47	
Chambers (1946) ¹²	100	34	First attacks only
Mintz and Katz (1947) ¹³	572	22	
Yater et al (1948) ¹⁴	866	52	Young adults; 4 wk. period
Wright et al (1948) ¹⁵	368	24	
Tulloch and Gilchrist (1950) ⁵	503	33	
East and Beamish (1951) ¹⁶	100	47	

It is seen from Table 1 (modified from Tulloch and Gilchrist⁵) that the rate varies widely (from 16% to 54%) in the published reports. This is no doubt in part due to hospitalization of severely ill patients only in some communities, and to admission of greater numbers of less critically ill patients in others. It is generally agreed also that the mortality is lower in first attacks and higher in younger persons. Tulloch and Gilchrist⁵ have recently assessed their Edinburgh experience from two series of hospital patients, the first being composed of one hundred consecutive cases of coronary thrombosis observed during the period 1939-46, before the introduction of anticoagulants; their mortality rate was 43%. A second series of eighty-four consecutive patients observed concurrently with a similar number receiving anticoagulants had a mortality rate of 41%. In a series of 503 cases drawn from Belfast, Glasgow, Manchester and Edinburgh, the over-all mortality rate was 33%. Our own experience at the Winnipeg General Hospital is comparable. In 100 cases of acute myocardial infarction admitted since June, 1946, and not treated with anticoagulants the hospital mortality was 47%.

It is now necessary to determine the cause of this high mortality. The causes of death following myocardial infarction have been extensively studied and it has become apparent that the most common complications of coronary occlusion with myocardial infarction are thromboembolic. These include thromboembolic complications within the heart itself and those which occur in the vascular system elsewhere in the body. Intracardiac thromboembolic complications include extensions of the initial coronary thrombus, formation of new coronary thrombi in the same or in

other coronary arteries, and the formation of mural thrombi within the cardiac chambers. Mural thrombi frequently give rise to emboli which enter the systemic or pulmonary vessels. Extracardiac thromboembolic complications include peripheral venous thrombosis with resulting pulmonary embolism, and peripheral arterial thrombi. Selzer¹⁷ has pointed out that nearly 50% of patients who die during the acute stage of infarction, die not from the cardiac insult per se but from secondary complications.

Table II indicates the cause of death in 65 of our fatal cases. It is seen that 41.5% of these patients died from thromboembolic complications. It is obvious that if these could be prevented the mortality could be almost halved. The prospect of achieving this provides the rationale for the use of anticoagulants.

TABLE II
Results of Standard Treatment
II — The Cause of the Mortality
(65 cases — 29 with autopsy)

CAUSE OF DEATH	No.	%
Thromboembolic Complications	27	41.5
Further infarction	13	
Systemic emboli	4	
Pulmonary emboli	8	
Cerebral emboli	2	
Shock and Collapse	20	30.5
Congestive Heart Failure	9	14.0
Arrhythmias	5	7.5
Other	4	6.5
	65	100.0

Anticoagulant Therapy

(1) Experimental and Clinical Observations

Solandt and Best in 1938-39 showed that heparin effectively prevented both coronary thrombosis and the formation of mural thrombi in experimental canine coronary thrombosis. It was not until 1942 that Dicumarol began to be employed in patients with myocardial infarction; by 1946 several investigators had reported favourable results. The American Heart Association then established a Committee for the Evaluation of Anticoagulants in the Treatment of Coronary Thrombosis with Myocardial Infarction. This Committee was composed of cardiologists associated with sixteen leading American hospitals. Three hundred and sixty-eight patients admitted to the participating services on even days received conventional therapy and constituted the control group. Four hundred and thirty-two patients admitted on odd days received anticoagulants in addition to conventional therapy and constituted the treated group. The effect of anticoagulants on mortality is shown in Figure 4.¹⁸ It is seen that 24% of the control patients died, whereas 15% of the treated patients died. Thus, somewhat more than one-third of the individuals who would have died without anticoagulant therapy survived when anticoagulants were given. It is apparent from the figure that this reduction in mortality is largely

due to a decrease in those deaths following one or more thromboembolic complications. The Committee has now reported¹⁸ a total of one thousand and thirty-one cases with approximately the same results. In addition to the reduction in death rate there is also the important benefit of reduced non-lethal thromboembolic complications, such as hemiplegia and peripheral gangrene. On the basis of this study the Committee has recommended that anticoagulant therapy should be used in cases of acute coronary thrombosis unless a definite contraindication exists.

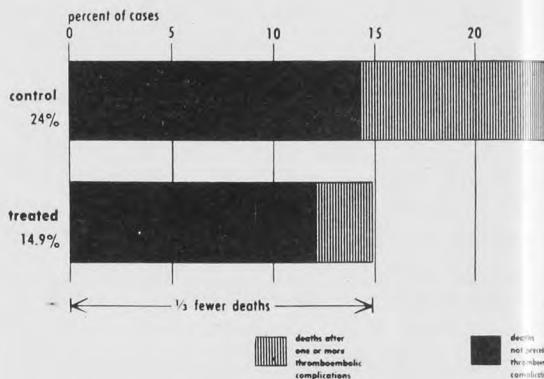


FIG. 4

Anticoagulants in the treatment of coronary thrombosis with myocardial infarction. Patients dying in the control and treated groups under study. (Reproduced from the American Heart Journal, 36: 1948, with the kind permission of Dr. I. S. Wright and the Editors and Publishers of the American Heart Journal.)

Since the publication of the favourable results in this large series there have been a number of confirmatory reports. Others have felt, however, that the routine use of anticoagulants for acute myocardial infarction on the wards of a busy general hospital does not significantly improve the prognosis.¹⁹ Accordingly a series¹⁶ had been collected from the records of the Winnipeg General Hospital; during the period dating from June 1946, to March, 1950, there were 221 cases of confirmed myocardial infarction admitted to the hospital, and of these, 108 or 48.9% received anticoagulant treatment. Whether patients received anticoagulants or not depended entirely upon the practice of the attending physician; there was at this time no control study of the effect of anticoagulants being carried on in the hospital. When patients who died of non-cardiac causes, and those who died within two days of admission (and therefore before anticoagulant therapy could be effective) were excluded, there remained a series of 100 "treated" cases and 100 control cases. In the untreated or "control" series there was a hospital mortality of 47% whereas in the "treated" patients the mortality was only 11%. This very striking reduction in mortality is doubtless not entirely due to anticoagulant treatment, as the two series are not strictly comparable.

nevertheless that these figures are not without meaning is indicated by their similarity to the figures of other authors (Table III).

TABLE III
Mortality Rates in Cases Treated
With and Without Anticoagulants
"ANTICOAGULANT"
CASES

AUTHOR	Total	Deaths	Total	Deaths
Peters et al (1946) ²⁰	50	2	60	13
Greisman and Marcus (1948) ²¹	75	7	100	35
Glueck et al (1948) ²²	44	9	44	20
Wright et al (1948) ¹⁵	432	65	368	88
Parker and Barker (1948) ²³	100	11		
Hilton et al (1949) ²⁴	38	5	76	18
Schilling (1950) ²⁵	60	10	60	24
Bresnick et al (1950) ¹⁹	60	10	60	24
Tulloch and Gilchrist (1950) ⁵	70	16	84	34
East and Beamish (1951) ¹⁶	100	11	100	47
	1091	159	1020	295
MORTALITY RATE	14.6%		28.9%	

Table III shows mortality rates in cases treated with and without anticoagulants in a large collected series. It is seen that anticoagulant therapy has reduced the mortality by one-half. Significantly, this is precisely the reduction in mortality that was predicted if thromboembolic complications could be prevented.

The view that all patients with myocardial infarctions should receive anticoagulants has been challenged recently, in America by Russek and colleagues²⁶ from Staten Island, N.Y., and by Papp and Shirley Smith²⁷ in England. These authors point out that the prognosis for mild and uncomplicated cases of myocardial infarction is so good that anticoagulants are unnecessary. Russek et al state that anticoagulants need only be given in "poor risk" patients who have had previous infarction, intractable pain, persistent shock, congestive heart failure, gallop rhythm, arrhythmias, or complicating diseases. Applying the criteria of Russek et al to our material as best we could, we found that our "poor risk" patients who received anticoagulants had a mortality of 20% and the "good risk" patients had a mortality of 8.5%. In the patients who did not receive anticoagulants, 58% of the "poor risk" and 35% of "good risk" patients died. This means either that our criteria are wrong or that anticoagulants are very definitely indicated in both "good" and "bad" risk cases. Moreover, it is our feeling that one cannot grade cases as mild or severe at the onset when the physician first sees the patient; such grading can only be done in retrospect. It is possible that an error in grading by the physician might cost the patient his life. The evolution of a fatal cardiac infarction beginning as a "mild" coronary attack is illustrated by the following patient:

Case Report

A man aged 55 years began in July, 1950, to have tight, pressing pain in the left retrosternal area on exertion. It radiated to the left anterior axillary line and through to the left scapula; it was accompanied by slight ache on the outer aspect

of the left arm in the deltoid region. It would appear after walking the distance of one city block, but was rapidly relieved by rest. There was no change in this symptom for a year but on July 5th, 1951, while walking he developed a very severe pain in the usual region; this pain persisted for an hour although he sat down and rested. When the pain finally disappeared he went home by streetcar but noticed that when he made his way from the car stop to his home, the pain recurred frequently. The same afternoon he went to see his doctor who recorded examination of the heart to be normal, blood pressure 120/80, pulse 60. An electrocardiogram (Figure 5, tracing 5.7.51) was normal. In spite of these negative findings he was advised to go into hospital and was accordingly admitted to the Winnipeg General Hospital the following day, July 6, 1951.

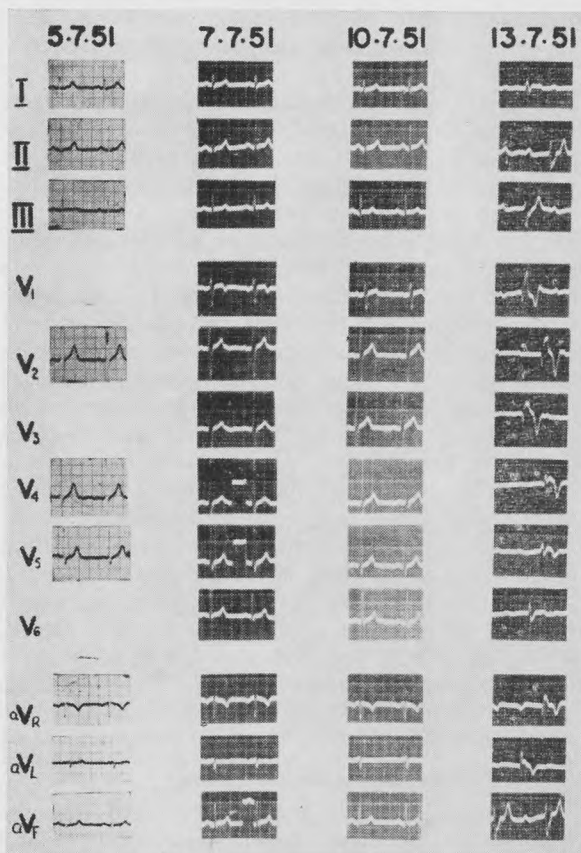


FIG. 5

Evolution of a fatal myocardial infarction. Details in text.

On admission his temperature was normal, pulse 80, blood pressure 138/88, and leucocyte count was 7,800. He was no longer experiencing any pain. His electrocardiogram was repeated the following day (Figure 5, tracing 7.7.51) and it showed an abnormal inversion of the T waves in leads V-I and aVL only. He continued to feel well and a sedimentation rate on July 9th, 1951, was 5

mm. As he continued to feel well the attending physician considered that he could be sent home.

On July 10th, 1951, his electrocardiogram was repeated (Figure 5, tracing 10.7.51). The previously noted abnormal T wave in V-I was now seen to be more normal in appearance. He continued to do well until July 12th when his pain began to recur. By July 13th he was having continuous severe pain and looked very ill. His electrocardiogram (Figure 5, tracing 13.7.51) now showed 2:1 heart block, right bundle branch block, and an obvious anteroseptal myocardial infarction. He was now started on Dicumarol but died on July 14th before prothrombin time had been affected.

Necropsy showed a thrombotic occlusion of the anterior descending branch of the left coronary artery with anterior myocardial infarction.

During the year that this man suffered from angina of effort it would appear that the state of his coronary circulation was static. Then suddenly one day a great change occurred; he experienced a severe cardiac pain which persisted at rest and following this he found that his pain came on much easier and was much more severe, and yet examination revealed no change in his condition—his pulse and blood pressure remained normal; he did not have a leucocytosis or an elevated sedimentation rate, and the nine electrocardiographic leads which were taken were normal. This is the typical picture of coronary thrombosis without infarction. A more complete electrocardiogram taken two days later showed ischemic changes in two leads only and these soon improved. Two days later, at a time when he was free of pain, his examination normal, and his electrocardiogram improved, he suddenly developed severe pain and a fatal myocardial infarct. During the week of observation preceding this final episode he could only be considered to have a "mild" attack. A day later, however, he would certainly have to be graded as a "severe" attack. It is obvious now that this was a case of impending myocardial infarction and had anticoagulants been given the outcome might have been quite different.

(2) Technique and Administration

Anticoagulants in common use are heparin, Dicumarol, Danilone, (phenylindanedione), and Tromexan. Each of these substances has certain advantages and disadvantages. Heparin, the first anticoagulant to be used successfully in man, has the virtue of almost instantaneous action but unfortunately has to be given by injection. Dicumarol, Danilone and Tromexan are administered orally but have the disadvantage that their effect is delayed from 48 to 72 hours with Dicumarol, and from 24 to 36 hours with Danilone and Tromexan. To obviate these disadvantages combined use of heparin and the oral anticoagulants has been

widely adopted.

In treatment of coronary thrombosis with myocardial infarction, it has not been established that use of heparin improves results but it seems reasonable to suppose that the first hours after infarction (when circulation is at its lowest) is the time when interference with the clotting mechanism is most needed. In patients with coronary thrombosis not accompanied by infarction, and in whom it is hoped to prevent infarction it is obvious that the rapidly acting heparin must be given. For these reasons it has been our practice to combine therapy as follows:

Heparin and Dicumarol are administered simultaneously at the beginning of treatment, the heparin being continued only until the prothrombin time is prolonged as a result of the Dicumarol. Heparin is injected intravenously in doses of 500 mg. every four hours and theoretically dose should be controlled by determination of the clotting time before each injection. In hospital patients receiving heparin for short periods have regularly omitted determinations of clotting time since it entails considerable technical work and numerous venipunctures—to date we have not had occasion to regret this departure from the recommended orthodox practice. Dicumarol is administered orally in a dose of 300 mg. as soon as the prothrombin time has been determined and then found normal. Next day the prothrombin time is again determined, and depending on its value a dose of 200 mg. or less is given. On the third day the prothrombin time is usually adequately lengthened (around 35% of normal), heparin then discontinued, and Dicumarol alone in doses of 25 to 100 mg. is given daily or as required to keep the daily prothrombin determinations at therapeutic level. It is always important to know what method of prothrombin time determination the laboratory is using and what the therapeutic range is for that particular method. Dicumarol is usually given for four weeks, or at least until the patient is ambulant. Variations in daily dose of Dicumarol in a patient who recovered unequivocally from a myocardial infarction are illustrated in Figure 6.

Either Danilone or Tromexan may be substituted for Dicumarol in the above treatment plan. Since their effect is more rapid it is usually possible to discontinue heparin a day sooner than with Dicumarol, thus saving the patient a number of venipunctures. Recommended initial dose of Danilone is 150 to 200 mg. in two divided doses the first day, then a daily maintenance dose of 25 to 100 mg. as required to control prothrombin time. When the maintenance dose exceeds 25 mg. per day, it has been our practice to give it in divided doses. Satisfactory control of prothrombin time with Danilone is illustrated in Figure 7. We have now used Danilone extensively and find it very satisfactory.

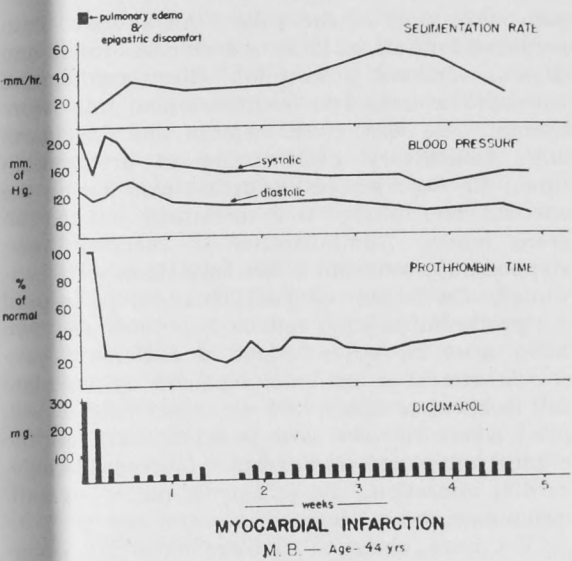


FIG. 6
Treatment of myocardial infarction with Dicumarol.

Dosage of Tromexan is much larger than that of Dicumarol or Danilone. The initial dose is usually 1,500 mg. and the maintenance dose 600 to 900 mg. daily in divided doses. Our experience with this substance is limited but there is no doubt that it is a safe and effective anticoagulant. Figure 8 illustrates satisfactory control of prothrombin time as long as adequate doses were given. As in the case of Danilone, prothrombin time rapidly

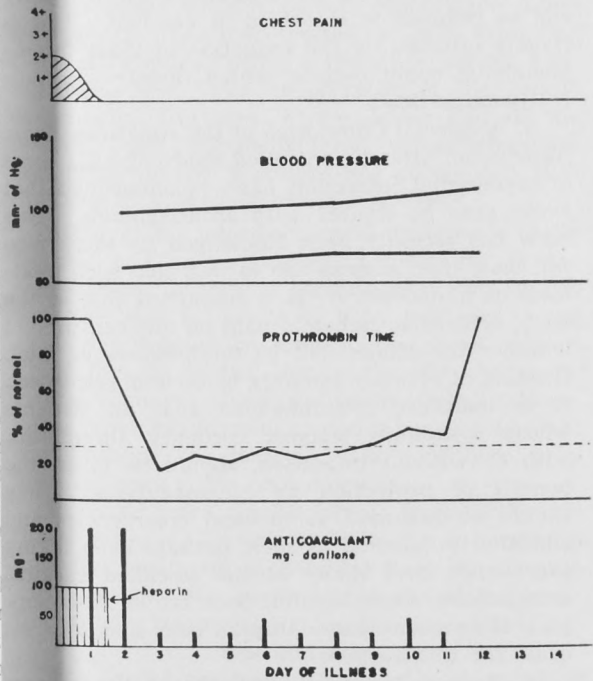


FIG. 7
Treatment of impending myocardial infarction with Danilone.

returns to normal if the drug is given in inadequate dosage or discontinued. The rapidity with which the effects of Tromexan and Danilone wear off makes it imperative that the daily maintenance dose be adequate, and that the dose not be inadvertently omitted. With the slower acting Dicumarol there is less chance of the prothrombin time suddenly rising above the therapeutic range.

(3) Dangers and Contraindications

The danger in anticoagulant therapy is from hemorrhage. For this reason the treatment should only be given in hospital (at least until the maintenance dose is well established) and then only if adequate laboratory facilities are available. Patients should be watched for hematuria,

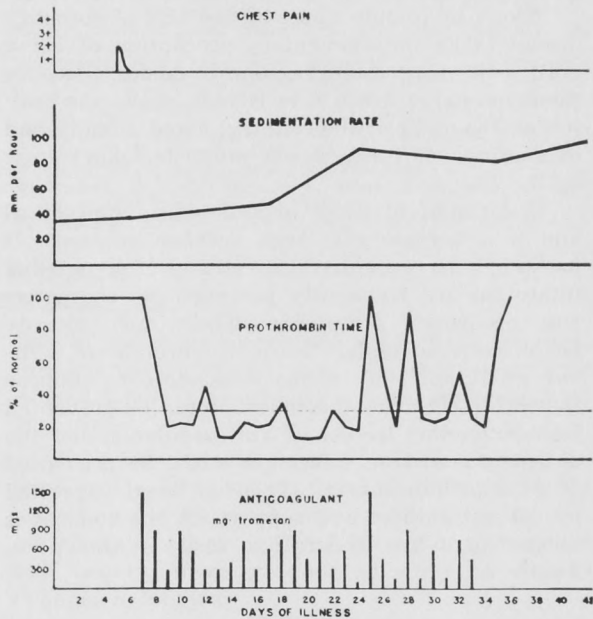


FIG. 8
Treatment of myocardial infarction with Tromexan. Details in text.

epistaxis and other evidence of bleeding. Minor degrees of bleeding can be expected in from 5 to 10 per cent of patients; serious hemorrhage is not common in patients who are carefully controlled. When hemorrhage does occur anticoagulants must of course be discontinued and if blood loss is appreciable it should be replaced by transfusion. Hemorrhage due to heparin may be controlled by protamine sulfate (2 mg/Kg) intravenously. Bleeding due to Dicumarol may be controlled by Vitamin K in doses of 75 mg. intravenously every four hours until the prothrombin time returns to a safe level. It is said that the risk of hemorrhage is less with Danilone and Tromexan but serious hemorrhage may follow their use. Vitamin K has no effect in counteracting the effects of Danilone but appears to be of value as an antidote for Tromexan.

Anticoagulants should be used cautiously, if at all, in patients with hepatic or renal damage, hypoprothrombinemia, blood dyscrasias, recent operations on the central nervous system, or recent surgical wounds with raw surfaces.

Prevention of Myocardial Infarction

It is seen from Table II that if thromboembolic complications are eliminated, as most of them can be by the use of anticoagulants, the leading cause of death following myocardial infarction is shock and collapse. Since treatment of this has been so unsatisfactory, the next step toward lowering the mortality from coronary thrombosis must be prevention. Ideally this can best be achieved by following the advice of Dr. Donald R. Reid of London as quoted in "Time," July 2nd, 1951:

"Don't be unduly upset by the risk of coronary disease; take the elementary precaution of being born a woman; don't become a doctor (because their coronary) death rate is 20% above the rest; live in the quiet of the country; avoid anxiety and overeating. In other words, laugh but don't grow fat."

Unfortunately these measures are impractical and it is necessary to seek another solution. It has long been recognized that attacks of myocardial infarction are frequently preceded by characteristic prodromal symptoms. These have already been described under "coronary thrombosis without infarction." It seems reasonable to suppose that if the coronary thrombosis could be prevented from extending by use of anticoagulants, and the patient put at rest, infarction might be prevented or at least minimized. This has been suggested by several authors and support for the concept is increasing. An illustrative case is shown in Figure 9.

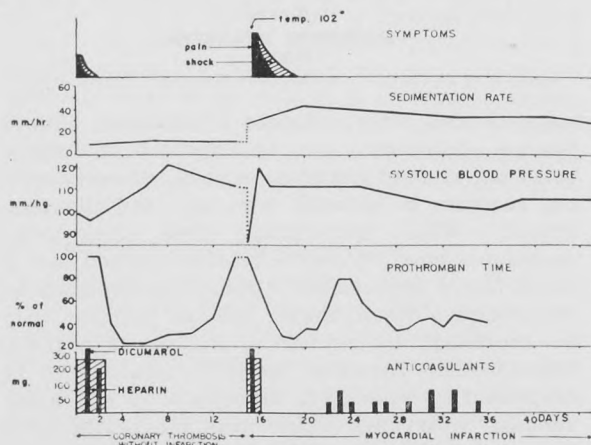


FIG. 9

Anticoagulants in the prevention of myocardial infarction. Details in text.

Case Report

A seventy-year-old man who had been symptom free suddenly developed a moderate cardiac

pain while painting the walls of his kitchen. It persisted for half an hour; a doctor was called and he was admitted to hospital. Electrocardiogram, leucocyte count, and sedimentation rate were normal. He was given heparin and Dicumarol with satisfactory prolongation of prothrombin time. He experienced no further pain during the ensuing two weeks and thereupon insisted on going home. Administration of Dicumarol was stopped but prothrombin determinations were continued. On the day of his discharge from hospital his prothrombin time returned to 100% and five hours after he arrived home he suffered a severe attack of pain accompanied by transient fall in blood pressure. He was readmitted to hospital where he was now found to have all the clinical and electrocardiographic evidences of a myocardial infarction. He was again placed on anticoagulants and made an uneventful recovery.

We have observed similar immediate occurrence of infarction several times when anticoagulants have been discontinued—even after 3 or 5 weeks of administration. It would appear that when anticoagulants are given to prevent impending infarction they need to be continued for a prolonged period.

Summary and Conclusions

1. Treatment of myocardial infarction in the past has been attended with a high mortality. About one-third to one-half of deaths after infarction have been due to thromboembolic complications.

2. By the use of anticoagulants the mortality can be reduced to one-third or one-half. This is largely effected by the reduction of those thromboembolic complications which directly or indirectly cause death.

3. A Special Committee of the American Heart Association after a controlled study of 1,031 cases of myocardial infarction have recommended that every case be treated with anticoagulants. This view has recently been challenged by those who say that "mild attacks" do so well that such treatment is unnecessary. It is submitted that at onset of cardiac ischemic pain no one can predict whether the attack will be mild, severe or fatal. Grading of severity can only be done in retrospect. It is therefore recommended that all patients whose symptoms suggest coronary thrombosis with or without infarction, should be given the benefit of protection by anticoagulants. This should be regarded as medical emergencies and admitted to hospital as such, perhaps even taking precedence over many of the so-called surgical emergencies when hospital beds are in short supply. If necessary more hospital beds should be set aside for this purpose.

4. It must be emphasized that anticoagulants should be administered only by persons having access to adequate laboratory facilities.

physician must also be prepared to take the time and trouble to become familiar with the pitfalls and finer ramifications of this therapy. In some areas this may mean that facilities will have to be provided; in others, it may mean patients have to be moved to where facilities are available. Any one of several drugs may be used successfully, but the casual user should select one and become thoroughly familiar with it.

5. When anticoagulants are properly used, the leading cause of death following myocardial infarction is shock and collapse. Measures to counteract this have been disappointing. Best hope at present for further reducing mortality is the administration of anticoagulants in the prodromal period before actual infarction occurs. We are now doing this and results are encouraging.

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Orthopedics

Treatment of Intertrochanteric Fractures

A Survey of Cases Treated by Conservative and Operative Methods

N. R. Kippen, M.D.

This series consists of 112 consecutive intertrochanteric fractures treated at the Winnipeg General Hospital during a five-year period, ending June, 1950. For the purpose of this study, comminuted fractures of the upper end of the femoral shaft, pertrochanteric, transtrochanteric and extracapsular fractures are considered subdivisions of intertrochanteric fractures.¹

Although the intertrochanteric fracture is easily reduced and unites readily, a mortality in the neighborhood of 20% is considered inevitable. In part, this may be due to its high incidence in the aged who frequently present associated lesions. These include cardiac, renal, diabetic and senile mental changes. Conservative treatment necessitating prolonged immobilization is poorly tolerated; complications are common, and contribute in a large measure to the high mortality.

In recent years, reports largely from the United States indicate a significant reduction in mortality following treatment by internal fixation. Despite such accounts, the treatment of choice for intertrochanteric fractures still remains controversial.

Age and Sex

The age of greatest incidence for fractures of the femoral neck is between fifty and sixty years. Patients with intertrochanteric fractures average

five to ten years older than those with fractures through the cervical region. In this series ages ranged from 18 to 96 years, with an average of 70.5 years.

Sixty-six patients were females and forty-six were males. The preponderance of females is in accordance with most reported series. A suggested explanation is the lighter bony structure and usually more pronounced atrophic osseous changes in women.²

Methods of Treatment

Of the 60 patients treated conservatively, skeletal traction was used in 35 instances. This was maintained through a Steinman pin or Kirschner wire in the upper end of the tibia. In the remainder, Buck's extension, traction followed by a plaster spica, or bed rest with or without the support of sandbags was the method employed. Well-leg traction was not applied to any patient in this series.

In the 52 patients treated surgically, the fracture was held by internal fixation. The Smith-Petersen nail with the Thornton attachment was used in 29 cases; the Blount-Moore blade plate in 17; the Smith-Petersen nail alone in 4; and the Moriera stud-bolt screw in 2 patients.

The one disadvantage of the combination nail and plate is its instability at the juncture of the nail and plate which may allow comminuted fractures to develop a coxa vara deformity during subsequent months. Loosening of the screw hold-

ing the nail and plate attached is largely overcome by the addition of a lock washer.

The blade-plate devised by Blount and Moore is stronger and can be bent to the proper angle by means of special irons. The newer type with the curved blade does not tend to cut out of the femoral head. Neufeld's V-shaped nail and



FIG. 1

Intertrochanteric fracture of the femur treated with a Smith-Petersen three flanged nail and lateral plate.

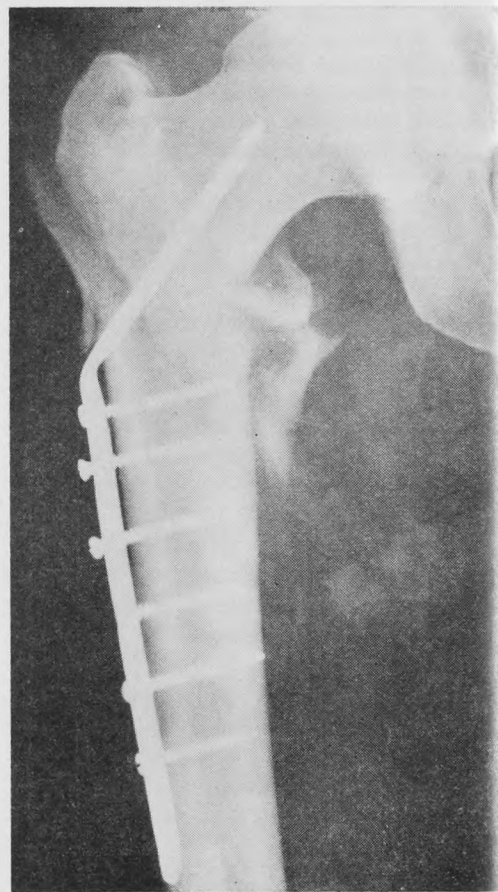


FIG. 2

Slightly comminuted intertrochanteric fracture of the femur treated by means of a Blount-Moore blade plate.

Jewett's nail and plate are cast in one piece and do away with most of the angle weakness. The guide wire is followed more closely than in the Moore type. They must be available in a variety of lengths and angles at operation.

Results of Conservative Treatment and Internal Fixation Compared

Table I summarises the hospital stay of 60 patients treated conservatively. Traction through the upper end of the tibia had some advantages over other methods of treatment used in this group. Shortening and external rotation deformity were overcome. The rotating stirrup permitted flexion and extension of the knee, preventing much of the stiffness which followed other conservative methods.

Table I

Average age (28-96 years)	74.5 years
Deaths (33.3%)	20
Average survival time (deaths)	6.8 weeks
Time in traction (survivors)	8 weeks
Length of stay in Hospital (survivors)	9.3 weeks

The age of patients treated conservatively was on an average 10.6 years older than those selected for operative management. It would appear that many patients were considered unsuitable for internal fixation because of their advanced age and general debility.

A comparison of mortality in this group of patients presented in Table II is not significant, because selection of cases could not be excluded.

Table II

Average age (18-85 years)	63.9 years
Deaths (5.8%)	3
Length of stay in bed (2 days-7 weeks)	1.6 weeks
Length of stay in Hospital (2 weeks-26 weeks)	5.2 weeks

Table II summarises 52 patients treated by internal fixation. Operation was carried out under intermittent fluoroscopic control—with this technique, reduction and position of the guide wire could be checked by an x-ray film whenever necessary. While the majority of patients in this group were younger and probably better candidates to withstand surgery than in the preceding group, this was not always so. Two case histories are presented as examples:

Case 1.

Mrs. E. C., age 77 years, was admitted to hospital on April 17, 1950, during an acute asthmatic attack. She had suffered from Bronchial Asthma for the previous twenty years. A disseminated pyodermitis over the neck, trunk and extremities has been present for some 5 years. Examination revealed a frail woman whose chest movements were moderately restricted. Creps and ronchi were heard in both upper lung fields. There was evidence of moderately advanced emphysema. White blood count was 5,100; sedimentation rate 31 mms.; and hemoglobin 13 gm.

April 20th, three days after admission, the patient fell out of bed, sustaining an intertrochanteric fracture of the left femur. For the next 48 hours, the limb was supported by sandbags while awaiting a medical opinion regarding operation. During this time, her general condition rapidly deteriorated and she became confused and involuntary. It was felt that in spite of being a poor surgical risk, operative treatment should be undertaken as the patient would not tolerate immobilization.

On April 22nd the fracture was fixed with a Smith-Petersen nail and attached plate under general anaesthesia. The patient received 500 ml. of blood during the operation and withstood the procedure well. She sat up in a chair from the second post-operative day. Her general condition readily improved and she became rational and cooperative. On May 15, 1950, the patient was discharged from the hospital during the flood, having made an uneventful recovery.

Case 2.

Mrs. A. O., age 64 years; entered hospital February 26, 1950, for abdominal paracentesis. She had suffered Laennec's cirrhosis for two years, and had been admitted on numerous occasions for removal of ascitic fluid. She was undressed during most of this time and complained of increasing fatigue.

On May 1st, 1950, while still in hospital, the patient fell out of bed. X-ray revealed an intertrochanteric fracture of the right hip. Examination showed an obese, jaundiced, mentally retarded woman. She was drowsy, confused and presented evidence of generalized arteriosclerosis. Attempts at paracentesis had been unsuccessful and abdominal distention was marked as well as gross pitting

oedema of the ankles. Blood examination gave a leucocyte count of 4,900; sedimentation rate of 118 mms.; and hemoglobin 10.1 gm. (65%). Prothrombin time was normal, serum bilirubin 8.2 mgm.%; and the albumin globulin ratio was reversed.

On May 2nd internal fixation with a Smith-Petersen nail and lateral plate was performed. Operation was carried out under general anaesthesia; 500 ml. of blood being administered during the procedure. The patient was up in a chair from the second post-operative day. Convalescence was uneventful.

This patient died 8 months later from bronchopneumonia and portal cirrhosis. However, it was felt that internal fixation had been justified in this case as the immediate prognosis was improved and nursing care greatly facilitated.

Complications

Of the patients treated conservatively, 48.3% developed one or more complications during their hospital stay. Hypostatic or bronchopneumonia was encountered in 12 patients, and a similar number developed decubitus ulcers. Senile psychosis developed in 9 other patients, an incidence of 15%. Of the remaining 6 individuals in whom complications occurred, infection along the pin track accounted for 2; furunculosis of the back, pulmonary embolism, ileus with abdominal distention and cystitis accounted for the remainder.

The incidence of complications was lower in the operative group being 30.7%. Bed sores were observed in 8 patients, while 4 developed some degree of senility. Wound infection occurred in 3 cases and post-operative atelectasis in one. Protrusion of the nail into the acetabulum was seen in one instance, and in another the nail tore out of the femoral head, necessitating its removal; treatment was continued in traction. Paralytic ileus and jaundice followed operation in one patient, and accounted for one of the fatalities.

Hospital Mortality

A mortality of 20% was observed for the entire series. The conservative group showed a mortality of 33.3%. 5 patients died between the fifth and seventh day of sustaining the injury but there were no deaths before this time. The average survival time was 6.8 weeks. Pneumonia accounted for 60% of the fatalities in this group.

Of the 52 patients treated by internal fixation, only three died; an incidence of 5.8% (Table II). One death occurred 7 days post-operatively from heart failure; another was the result of a cerebrovascular accident ten days following surgery; the third was a male patient, age 70 years, who developed abdominal distention and jaundice post-operatively and expired one week later.

Discussion

It is observed in the older age group selected for conservative treatment in this series that the aged patient who sustains an intertrochanteric

fracture tolerates immobilization poorly. Bed sores, chest complications and mental deterioration are frequent; cystitis, muscle atrophy and joint stiffness common; a high mortality is to be expected.

An average survival time of 6.8 weeks suggests that many had sufficient vitality to have withstood operation. It is in these patients that internal fixation may be life-saving. Improved anaesthesia, blood transfusions and other supportive measures have reduced the risk of surgery. Cleveland et al. reduced their mortality rate from 34% for conservative treatment to 12.6% by the routine nailing of all intertrochanteric fractures.³ A similar lowering of mortality has been reported by Evans, Harmon and Aronsson.^{4, 5, 6.}

Summary

1. A series of 112 intertrochanteric fractures is presented.
2. A comparison of morbidity and mortality is made of 60 patients treated conservatively and 52 patients treated by internal fixation.
3. Case histories of 2 patients treated by operation are presented.

Medicine

Congenital Syphilis in Manitoba

K. J. Backman, M.D., and E. L. Peters, M.D., M.P.H.
Incidence

The reported incidence of syphilis of all types in Manitoba has shown a dramatic decrease during the past four or five years, i.e., from six hundred and ninety-six (696) in 1942, six hundred and seventy-eight (678) in 1946 and four hundred and nineteen (419) in 1949 to two hundred and thirty-five (235) in 1950, (one hundred and sixteen (116) to August 31, 1951).

This has happened in the face of improved reporting of cases (as shown by cross checking against laboratory reports) and in the face of a consistent drive to find cases and contacts. Factors responsible for the favorable trend are: Improved therapeutic measures especially with the introduction of penicillin, vigorous epidemiological methods to bring sources and contacts under medical care, the constant follow-up of treated cases to detect relapses early, the deliberate overtreatment of gonorrhoea and non-specific urethritis cases with the view of eliminating any concomitantly acquired syphilis, and the good support given the control measures by the medical profession. No doubt the liberal use of penicillin for other concurrent ailments has also resulted in the cure of a certain number of early or hitherto undiagnosed cases which would subsequently have added to the annual number of reported cases. The general

4. An analysis of this series suggests that internal fixation has the advantages of early mobilization, shortening of hospital stay and low mortality.

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practice of taking premarital and prenatal serologic tests with consequent prompt treatment of positive cases has almost certainly been responsible for a decline in congenital syphilis.

Although statistics from Manitoba during the past nine years indicate that congenital syphilis has decreased very considerably, statements from authorities in Canada and the United States suggest that the decline in congenital syphilis has not been commensurate with the decrease in total syphilis.

The decrease in congenital syphilis in Manitoba occurred while in the same period live births increased from 15,719 in 1942 to 19,398 in 1950. However, even one case of congenital syphilis is called "negligent" syphilis, is one too many in the days of adequate diagnostic facilities and efficient of penicillin therapy.

Reported cases of syphilis in children under thirteen years of age, infant deaths under one year and stillbirths attributed to congenital syphilis are shown in Table I. This covers a nine-year period beginning 1942, the first full year in which the bureau of Venereal Disease Control was in operation with a uniform breakdown of statistics. To arrive at the correct incidence of congenital syphilis, reported cases, deaths and stillbirths have been combined totalling 142. Seven cases have been counted as both deaths and reported cases and have been counted only once in the total of 135.

In children a marked decline in reported cases is observed in all age groups and in infant deaths and stillbirths from syphilis. The increase in reported cases during 1947 and 1948 is particularly

attributed to an intensified effort to find and treat syphilis among Indians during those years. At least half of the deaths in 1947 were in Treaty Indians and the increase may therefore be more apparent than real. It is also observed that this rise occurred during the period of post-war adjustment.

Geographic and Racial Distribution of Congenital Syphilis

Prior to 1945, syphilis cases were reported by number only and it is therefore impossible to determine residence in all instances. However, it would seem that over the nine-year period studied, the number of reported congenital cases in Greater Winnipeg is approximately the same as for the rest of the province.

Deaths and stillbirths can be stated with more accuracy as these have been taken from vital statistics reports. Greater Winnipeg reported four deaths and ten stillbirths during this period while the rest of the province reported fourteen deaths and seven stillbirths.

Regarding the racial distribution this information is unfortunately not required on the notification of venereal disease forms. However, with the evidence available, it would appear that at least 25% of all reported cases are in Treaty Indians with the same number in Half-Breeds.

The racial distribution of deaths is more accurately known as the information is obtained for vital statistics purposes. Of the eighteen deaths recorded due to congenital syphilis, nine were in white babies and nine in Treaty Indians. Although not specifically stated, it is known that the "white" babies included several Metis.

The recorded incidence of still births due to congenital syphilis must be viewed with some skepticism. In some instances no confirmatory evidence was available that there was in fact syphilis, except a history of syphilis in the mother. Of the 17 cases recorded, 14 occurred in white babies and 3 in Treaty Indian babies. Our statistics indicate that the incidence of reported stillbirths due to other causes is relatively low among Treaty Indians and Metis.

Diagnosis

Congenital (or prenatal) syphilis is usually transmitted to the foetus in utero after the sixteenth week of pregnancy. When skin or mucous membrane lesions are present the diagnosis of congenital syphilis can be made by dark-field exam. The presence of characteristic skin or mucous membrane lesions together with a positive Serologic Test for Syphilis (S.T.S.) of the baby's blood is considered sufficient to establish a diagnosis.

In the absence of clinical signs of syphilis, reliance must be placed on repeated quantitative S.T.S. A child with a negative S.T.S. at birth should have tests repeated at 2-4 week intervals

for four months. If the test remains negative it is quite certain that the child does not have congenital syphilis. If, however, the test becomes positive, and is confirmed on repetition, a diagnosis of syphilis may be made.

Reagin from the mother's blood is frequently transmitted to the foetus while in utero with the result that positive S.T.S. may be found in an uninfected baby at birth. In such an infant the titre will drop to complete negativity without treatment within three months, indicating that the positive S.T.S. was simply the result of passive transfer of reagin from the mother. An apparently healthy baby should not be diagnosed as having congenital syphilis unless the S.T.S. shows an increasing amount of reagin or remains persistently positive in high titre.

The use of cord blood for S.T.S. is generally less satisfactory than venous blood as it may be haemolyzed or contaminated with cells or fluid. If carefully taken, the results with cord blood should be the same as with blood withdrawn from the veins of a newborn baby.

Confirmatory evidence of congenital syphilis may often be obtained from two weeks of age onward by x-ray exam, the lesions being observed most often at the epiphyseal line of the long bones.

Treatment

Penicillin is the treatment of choice and has been found exceptionally effective in infants. If clinical manifestations are present together with laboratory confirmation, treatment should be given immediately, but with no clinical evidence, treatment should never be started on one positive S.T.S. only. When the baby appears to be normal and diagnosis depends solely upon serological observations, treatment may safely be postponed for three months during observation period without jeopardizing the child's chance of being "cured."

Authorities differ somewhat as to the amount of penicillin required for effective treatment of syphilis in infants. The treatment schedule routinely employed at the Provincial Clinic is to administer intramuscularly, Procaine Penicillin G, 75,000-100,000 units once daily for fifteen days, or a total of 1-1½ million units.

Communicability

The infant with congenital syphilis is born in the secondary stage and is potentially infectious when moist lesions are present. Without treatment a congenital syphilitic is considered non-infectious after two years of age. He will not transmit the infection in adult life through sexual contact.

Women with congenital syphilis usually do not transmit the infection to the foetus during pregnancy but apparently may do so if untreated in 4% of cases.*

*Earl Moore: Modern Therapy of Syphilis.

Prevention of Congenital Syphilis

Penicillin is almost 100% successful in preventing congenital syphilis through treatment of the mother during early pregnancy, and may "cure" if given before term. The earlier treatment is given, the better.

An effective preventive program can be accomplished only through the co-operation of the expectant mother and her physician. The pregnant woman should have medical care throughout pregnancy and a routine diagnostic S.T.S. should be taken early in pregnancy and again in the last trimester.

A pregnant woman who is found to have syphilis should have prompt treatment. The best results for the child are obtained if treatment is given before the sixteenth week of pregnancy and provided patients are kept under observation and re-treated if they relapse. Regardless of the amount of penicillin given, patients should be observed and S.T.S. taken at monthly intervals until confinement. It is sometimes recommended that additional penicillin be given in the last six weeks of pregnancy in the event of relapse or re-infection which would not be demonstrable by laboratory tests.

The management of the pregnant woman who has received treatment for syphilis prior to pregnancy may present a problem. She will require close observation with frequent S.T.S. and if in doubt about the status of her case it is better to administer a course of penicillin than to run even a small risk of congenital syphilis.

There are no statistics available on prenatal S.T.S. This is due partly to the wording of the question relating to S.T.S. on the "Notification of

Live Birth or Stillbirth" card and also to the fact that when submitting blood specimens for S.T.S. no indication is given whether this is a pre-natal test or not, except in cases where the red-stained card requesting a test for the Rh factor is used. Renal forms have now been distributed.

The active assistance of all physicians is essential in preventing congenital syphilis:

(a) Include S.T.S. on all prenatal patients, early and late in pregnancy.

(b) Give immediate penicillin if syphilis is present.

(c) Follow-up with monthly serologic tests to detect relapse or resistance.

(d) Complete fully all forms relating to notification of births or venereal disease card or report labels for laboratory specimens.

TABLE I
Congenital Syphilis in Manitoba 1942-50
Reported Cases Under Thirteen Years, Deaths Under
Year and Stillbirths

— REPORTED CASES —

Year	Under 1 Yr.	1 to 4 Yrs.	5 to 13 Yrs.	Total	Infant Deaths	Stillbirths
1942	7	6	15	28	3	6
1943	5	2	7	14	3	1
1944	10	1	5	16	3	1
1945	5	1	3	9	3	1
1946	3	0	6	9	0	1
1947	7	0	9	16	6	1
1948	5	2	4	11	1	1
1949	1	4	2	7	0	0
1950	0	1	3	4	0	0
Total	43	17	54	114	18	17

*Seven deaths were also reported as cases and are only once in total.

**Data from Bureau of Venereal Disease Control and Statistics Division.

Clinico-Pathological Conference

St. Boniface Hospital

October 28, 1951

Torsion of Oviduct; Dermoid Cyst

Discussed by Dr. R. O. Burrell, Surgeon, St. Boniface Hospital.

Moderator: Dr. F. H. Burgoyne, Pathologist, St. Boniface Hospital.

Mrs. M. T., age 31. Race, Ukrainian. Admitted August 31, 1951. History taken September 1, 1951. E.C.

Sharp pain in left lower quadrant since August 31, 1951.

H.P.I.

The patient was perfectly well until 8 a.m. August 31, 1951, when she developed a sharp left lower quadrant pain which radiated through to the back. The patient became nauseated and began vomiting almost immediately. The sharp pain was gradually replaced by a dull ache which

persisted and finally assumed an intermittent character.

Past History:

Measles, whooping cough, chicken pox, scarlet fever, as a child, appendectomy 1939, T. & A.

Family History:

Mother was diabetic. Father has bronchitis. One brother has allergic rhinitis. One brother alive and well.

Personal History:

Born in Manitoba in 1920. Married in 1948.

R. of S.
General: Average weight 133 pounds, no variation recently.

Skin: Psoriasis (?) 1948.

Head: Frequent frontal headaches.

Resp.: Negative.

G.I.: Appetite good. Tendency to chronic constipation. Nausea and vomiting (see H.P.I.).
G.U.: Frequency since onset of present illness. Dysuria since onset of present illness.

Menstrual:

Menarche at 15.
Cycle 20-28 days—irregular
Duration 3 days—no dysmenorrhoea.
L.N.M.P. August 13, 1951.

Gynaecological:

Miscarriage (2 months) 1948.
Normal pregnancy 1948. No complications.

Physical Examination:

Well nourished adult female in no mental distress, under the influence of a sedative.

Head and neck: Negative, tonsillar tissue present.

Breast: No evidence of pregnancy.

Abdomen: Muscles of ant. abdominal wall are tense. There is tenderness in the L.L.Q. on light palpation. The tenderness was severe enough to prevent adequate palpation. No mass palpable due to muscle spasm.

Extremities: Negative.

Temperature normal on admission. September 1, 101 degrees. September 1-4, 99-100 degrees. Pulse 80-85 throughout hospital stay.

Laboratory:

August 31, 1951, Hematology; Hb 79%, 12.2 g.; R.B.C., 4.21 million; C.I., 0.94; W.B.C., 14,600; Eos., 91%; Lymph, 9%.

September 1, 1951, Urinalysis: Color, turbid-aw colored; pH, acid; Alb., ft. tr.; Sug., 0; Ketone, 0; Micro., 3-4 pus cells; occ'l red cell.

September 4, 1951: Sed. Rate, 80 mm.

September 5, 1951: Urinalysis; Acetone, mk. trace; Diacetic, 0.

Patient grouped and matched for 2 bottles of blood.

Progress Notes:

Patient given Demerol 100 mgms. p.r.n. for pain and observed.

August 31, 1951: P.V. exam. done by physician revealed a boggy mass in the mid-line extending forward the left. It was globular, size of large orange, appeared to move with the cervix and was extremely tender.

September 1, 1951: Friedman test done, negative.

September 2, 1951: P.V. done by physician.

Mass larger, more tender, felt to move independent of cervix and seemed to lie behind and forward the left side of the uterus.

September 4, 1951: Pelvic Laparotomy performed.

Dr. R. O. Burrell

A brief review of this history reveals the following salient points. The patient presented no symptoms of disease until August 31, when sudden onset of pain, radiating through to the back, associated with nausea and vomiting, suddenly appeared. This sharp pain subsided, becoming a dull ache which eventually assumed an intermittent character. In her past history psoriasis is mentioned but was not apparently present on this admission. Under the physical examination, "no evidence of pregnancy" is presented under the heading "breast." This is not an intelligent statement, as the breast is not an organ to indicate pregnancy in its early stages. Throughout her hospital stay she presented a slight elevation of temperature. On admission her blood count and hemoglobin were within normal limits. Apparently the doctor in attendance did not think this indicated intra-abdominal hemorrhage, as it was not repeated. However the patient was grouped and matched for blood, suggesting that he was preparing for that eventuality. Following is a schematic outline of causes of abdominal pain with which to eliminate various intra- and extra-abdominal lesions.

In discussing this case, one must think of the patient's age, sex and location of the pain. In extra-abdominal pain, this pain may be referred from the back. Sacro-iliac strain will produce such pain, however, no exacerbation on movement of the sacro-iliac joint is described by the patient.

Herpes may be ruled out by the presence of leukocytosis.

Lead colic: The onset of the symptoms were too sudden to suggest this condition.

Tabes: The location of the pain was in the wrong place. The pain lasted too long.

Pneumonia: No pulmonary disease was noted on physical examination.

Heart: The heart does not usually produce pain in the lower quadrants.

Acidosis: There was no acetone in the urine preoperatively, thereby ruling out acidosis. Therefore it may be concluded that the pain was not extra-abdominal.

Perforations:

Appendix: This is not likely. Pain was in the left lower quadrant. Unless there is transposition of viscera, the pain is not likely to be in the left lower quadrant. The onset of pain in appendicitis is not so dramatic.

Hemorrhagic pancreatitis: The patient is too young for this disease. She is not as ill as would

Extra-abdominal	Intra-abdominal	Obstruction	Inflammation	Colic	Hemorrhage
Back	Perforation	Mechanical	Appendix	Intestinal	Ectopic
Lead Poisoning	Appendix		Gall Bladder	Biliary	Ovulation
Tabes	Pancreas		Meckels	Renal	Strangulation
Pneumonia	Stomach		Diverticulitis	Tubal	Bowel
Heart Disease	Gall Bladder		Salpingitis		Omentum
Acidosis	Colon				Appendages
Herpes					

be likely.

For Stomach and Gall Bladder pain, the patient's complaints were again in the wrong location.

The Sigmoid and Pelvic Colon: Diverticulitis and Carcinoma are possible causes of pain in this location. However the age excludes such causes. No preliminary symptoms of such disease were evident. If a perforation of a viscus did occur, it is most probably located in the colon. However this is not likely.

Obstruction:

In favor of obstruction was the onset of vomiting almost immediately with the pain. However against obstruction was the character of the pain. It was sharp, referred to the back. It was replaced by a dull ache, which is also against obstructive pain. Obstructive pain is usually intermittent from the onset. There was no abdominal distension. There should be no tenderness or rigidity, and no leukocytosis.

Strangulation of the omentum due to torsion is a rare phenomenon. It can occur in any portion of the abdomen. It may be attached to liver, spleen, and so forth.

The abdominal appendages which may be strangulated are as follows: The Fallopian tube, the ovary, an ovarian or parovarian cyst or hydatid of morgagni. These are likely possibilities.

Hemorrhage: This may either be due to an ectopic gestation or due to ovulatory bleeding. Her last normal menses were on August 13. Therefore she should remenstruate on September 5 or 6. There could have been ovulation on August 31, although it is somewhat late. There is nothing to rule out ovulatory pain and hemorrhage.

Ectopic gestation: It would have been necessary for this patient to have become pregnant on August 26 or 27. This would have produced a 2 to 3-day-old fetus. A rupture of an ectopic gestation of this age is unlikely. The symptoms considerable size when it ruptures. Another basis for excluding an ectopic gestation with hemorrhage is the patient's blood count. She was not very anemic on admission.

Inflammatory Lesions:

Appendicitis, Cholecystitis and Diverticulitis, either Meckel's or Colonic, may be excluded because of the suddenness of pain.

Salpingitis may be suggested by the temperature and leucocytosis, but can be excluded by the normal Sedimentation Rate. The lesion was unilateral in this patient, not bilateral as is or in usual cases of acute salpingitis. Onset is usually not as dramatic.

Colics:

Intestinal: Intestinal colic is not referred to left lower quadrant. It is usually referred to the umbilicus.

Renal: There is usually not as much tender-

ness associated with renal colic.

Tubal: Ectopic gestation has been previously ruled out.

Thus the cause of this pain may be due to either ovulatory pain and hemorrhage or due to torsion and strangulation of an abdominal appendage. Pain is usually referred to the back because of a retroperitoneal origin for the viscus concerned. An example is the aorta, with a dissecting aneurysm. In the case of the pancreas, the blood supply of the organ concerned accounts for the site of referred pain.

Ovulatory pain: Does not usually pain in the back.

Ovary pain: This is usually referred to the lower first area. Therefore the cause of referred pain in this case may have been torsion of an ovary, ovarian cyst, or organ of Gerald.

Pelvic Examination: Revealed a boggy mass on the left side. It moved with the cervix. A pelvic hematocoele due to a ruptured ectopic pregnancy may produce such a mass. However it was last seen on September 2, moving independently of the cervix, thereby ruling out a hematocoele. The anatomical localization of the lesion may be said to be in the region of the ovary because of the location of the pelvic pain, its character, and referral to the back. This would include either a parovarian cyst or lesion involving the ovary. A negative Friedman test does not exclude ectopic pregnancy. The Sedimentation Rate could fit the possible lesion.

Discussion

Dr. Parkinson:

I would like to suggest two additional causes of pain localized to a lower quadrant referring to the back.

One such is an epidural abscess.

Another cause is an acute cord tumor.

These lesions may produce such symptoms which are usually left out of classifications of abdominal pain. They should be considered.

Dr. Burrell:

That is true. I did not think of these causes. Rheumatic fever in children may also produce such symptoms.

Dr. McEwen:

In cases of non-rotation of the appendix, the pain is usually in the mid-line. Pain may also appear in the left lower quadrant when the appendix is still on the right side.

Intern:

Would Dietl's crisis on the left side be a possibility?

Dr. Burrell:

No. The pain persisted too long. There was no muscle rigidity.

Dr. Burrell's Diagnosis:

Torsion and strangulation, left oviduct.

Pathological Diagnosis:

(1) Torsion and Strangulation, left oviduct and ovary.

(2) Dermoid cyst of Ovary.

Operative Report:

Peritoneum edematous. Large grapefruit sized mass. Irregular in outline. Hemorrhagic surface—quite cystic, almost black in spots. Left tube similar in appearance. Pedicle twisted 2 times upon itself. Omentum edematous. Right tube slightly edematous. Right ovary approximately 1 inch by 2½ inches; cystic.

Resected gangrenous left tube and ovary. Pedicle sutured to cornu of uterus—closed in layers. Nylon in skin.

Pathological Report:

Specimen consists of a hemorrhagic Fallopian tube and large multi-locular cystic mass dark red in color, measuring 12 x 12 x 16 cms. Fallopian tube measures 7 x 1.5 cm. On section cyst contains one large cavity measuring 7 cm. in diameter containing a cheesy reddish-white material. There is also an admixture of hair. The cyst contains 7 papillary outgrowths which have the appearance of skin. One of the outgrowths is thin walled and has the appearance of bowel. The cut surface of the skin-like nodules contains bones and teeth. The centres are hemorrhagic.

Micro:

Section of the dermoid reveals marked hemorrhagic necrosis with extensive areas of hemorrhage into the interstitial tissue. The lining of the dermoid cyst consists of squamous epithelium secreting keratinaceous material. The underlying connective tissue contains skin adnexa; sebaceous glands and hair follicles.

Hospital Clinical Report

St. Boniface Hospital

Reported by Dr. Lehmann

Gall-Bladder Disease

Dr. I. Pearlman discussed what "he referred to us" some points that may be worth while talking about.

He questioned the truth of the old theory that a "belching female of forty has gall stones." Such a patient could have indigestion without having gall stones. Even if gall stones were present they might have nothing to do with the dyspepsia. A woman whose gall-bladder contains "silent stones" is not likely to get rid of her indigestion by having the stones removed.

Dr. Pearlman pointed out that gall stones could form as the result of spasm of the sphincter of oddi and therefore did not always mean that the gall-bladder was diseased. The "prophylactic" removal of innocent stones was not likely to cure the

dyspeptic woman whose indigestion was due to something else, and a useless operation might make matters worse.

He considered treatment under two heads—surgical and medical. Surgical treatment is successful when there is no question about the presence of disease in the gall-bladder. He stressed the value of a definite history of colic or jaundice. Even if stones are present surgical treatment is not indicated unless there is a clear history of gall-bladder colic. The same caution applies to the poorly visualized gall-bladder. Surgical failures are often due to incorrect diagnosis.

Medical treatment of gall-bladder disease is uncertain and disappointing. If disease is actually present removal of the sac is the best treatment. When there is a question about the gall-bladder being the cause of the dyspepsia a search must be made to find out why the patient has indigestion.

In conclusion he repeated the advice given by Bockus—Take your time. Observe the patient. Check and re-check her before making up your mind to remove the gall-bladder of a patient who does not present the proper surgical indications for the extirpation of an important organ.

Case Presentation—Gun-shot Wound of Arm

Dr. H. Funk presented a 13-year-old lad who had shot away the front of his left forearm with a shotgun. Some of the pellets had also entered his anterior left chest wall.

On admission he was in mild shock and he was given A.T.S. anti-gas gangrene serum and penicillin and was immediately operated on.

Although no bony damage was present there was considerable soft tissue destruction. The flexor muscles of the forearm, except the flexor digitorum profundus and the flexor hallucis longus were largely destroyed. Functions mediated by the ulnar and median nerves were lost, but the radial nerve appeared intact, and adequate circulation was present in the hand.

At operation the ulnar was found to be transected, the median nerve lacerated only incompletely severed, the ulnar artery was completely severed and pulsations were absent in a segment of the radial artery.

The arm was debrided and the ulnar ends approximated but not sutured. A split thickness graft and a pressure dressing were applied. Most of the graft took.

This case illustrates the most successful operative technic for early injuries of this sort, namely:

(1) Adequate debridement.
(2) Conversion of an open wound into a closed one.

(3) The use of padded pressure by means of fluffed gauze and a Tensor bandage to prevent edema-formation and to aid the take of the graft.

Subsequent reconstructive surgery will be requested to give this lad a useful arm.

Article

The Patient Diagnoses the Doctor*

Judge J. M. George, K.C.
Morden, Man.

I appreciate the honor you have conferred on me by inviting me to address this august body of medical men assembled here this week. I consider your Convention an important one, being the annual occasion on which you get together to compare notes and find new or more efficient ways of serving suffering humanity, and to that end I wish you every success.

Being only a layman I regret that I am unable to contribute anything that may assist you in the practice of your profession, but am going to content myself in taking a look at you as a layman and as a patient, and have therefore selected as the topic of my talk to you "The Patient Diagnoses the Doctor."

I have had the experience of being both a medical and surgical patient in my brief span of life, and have been associated with doctors in many other ways, chiefly through my interest and activities in the hospital field of endeavour, and as chairman of the Health Advisory Commission for the past six years, on which body your Association has been well and ably represented. I think therefore I should be competent to express my views of the doctor from these various points of view but hope that in so doing I may not lose the goodwill that I believe, and hope, I have established with many of the outstanding members of your profession.

You may still doubt my ability to make the diagnosis I suggest, but you must recognize the fact that each one of us has some qualifications for any particular job we undertake. Let me illustrate:

A father was an M.D., and when his son, too, was graduated from Medical College the father took the lad on his rounds to teach him the fine art of diagnosis. In the first sick room they visited the father said to the patient: "You're eating too much candy, Mrs. Sykes. You'll have to cut it out."

"How right you are, doctor," she said, "and no more for me."

When the two physicians reached the street the son, in unfeigned admiration said, "That was an accurate diagnosis, Dad, how did you do it?"

"Observation, son. Notice the empty candy box in the waste basket and the candy wrappings on the table. Simple, eh? Now on the next case, you take over."

In the next house the son approached the bed, looked the lady over, and said: "Mrs. Dehydrant,

you'll save a lot of wear and tear, as well as needless worry, if you'll get yourself an electric refrigerator."

"How right you are, Doc." she said.

When they again reached the street, the father, now in admiration, said: "Say, that was swell. How did you arrive at that diagnosis?"

The son chuckled. "From under the bed I saw the iceman's feet sticking out."

As to my experience with you as a patient, I think I can say they proved satisfactory, at least. I can say, as you will see, I am still alive, and to enjoy the very sumptuous repast you were good enough to provide me with today.

As to my other associations, I do not hesitate to say that they have all been very happy experiences. During the past few years I have come to know doctors as men apart from medical matters, as I never knew them before, and those experiences have proven to me that their aim in life is not only to look forward to the privilege of distilling wisdom into the inner man and prying out a few of the faults that they consider no longer essential to the proper functioning of the body, but that as a profession you have that broad point of view that creates the desire in you to work with other men in other professions in uplifting humanity, not only physically but mentally and socially so that the world may be made a better place in which to live. To this end I have found leading members of your profession giving freely of their time and knowledge. I think one of the main faults we have, particularly as professional men, is that we too often become biased in our view points, and that we fail to take cognizance of and fully assess the other fellow's point of view. Let me illustrate: Pat and Mike while crossing a pasture field together attracted the attention of an angry bull, who, considering them trespassers in his domain, took to chasing them. Just as he was about to overtake Pat, in desperation, climbed a tree, and the bull jumped into a hole he found very convenient, the bull rushed by them. He had not gone far past when Mike bobbed his head up out of the hole and the bull, seeing him, renewed the chase. But Mike ducked back into the hole as the bull rushed past. This action on the part of Mike and the bull was repeated several times until Pat, who was still up in the tree, became so impatient that he called to Mike, saying: "If you don't stay in that hole we are never going to get out of this trouble." Mike replied: "That is alright for you, but you can't see everything from your point of view. There is a bear in the bottom of this hole."

You, as doctors, have your own point of view as to your qualities, qualifications and abilities, just in case you cannot see all of the problem

*Presented at the Annual Meeting of the Manitoba Medical Association, October 12th, 1951.

others from that point of view, I am going to take a look at you from the patient's point of view—possibly from the point of view of having to contend with a bear in the bottom of the hole. I am not going to take any unfair advantage of you by not warning you that I am going to put on rubber gloves and with the aid of a scalpel, needles, electrical and other gadgets of all kinds, I am going to examine you inwardly and outwardly. I may possibly stand you on your head, lay you on your stomach, or may go so far as to completely undress you and place you on your knees on a table before me with your head between your knees, in that embarrassing position in which you would not care to have your friends see you, but again, being fair, I will do this in private as you would, as I believe I am today talking to doctors only.

Should I put the needle in until it hurts, I assure you I will pull it out again and apply some such soothing ointment as Grand Elliptical Asiatic Anticancerous Nervous Cordial—I believe still unknown by that term to medical science—and also promise you I will restore you to your normal stature, so that you will feel fine and maybe better than before, perhaps only as a result of being relieved of the pain and misery through which I have put you, rather than from any good I have done you, such as I as a patient have experienced. I say to you as you would to a patient, this is not going to hurt—at least not much.

This may have seemed to you a long introduction to what you are expecting me to say about doctors, but is it not true that diagnostic procedures practised by you are sometimes also long and tedious—perhaps stalling for time to make up your mind as to where you should attack your victim—well, that is just what I am doing.

Doctors have various relationships with the public. These may be classified under the following headings: As an individual; as a general practitioner; as a specialist, and as an important part of hospital service. I may not have time to deal with all of those but will go as far as I can in the order given.

We must remember that the doctor is a human being like ourselves, subject to all the frailties to which mankind is subject, but being trained to relieve suffering and sooth the sick we cannot help but expect, rightly or wrongly, that through his training and the practice of his profession he will become more sympathetic, mildly mannered and more considerate in his association with others than the rest of us human beings. In forming such an opinion we may have overlooked the fact that, unlike people in other professions and occupations who may have varied experiences, every working hour of the doctor is spent on human individuals—individuals of all kinds—cantankerous, neurotic, stubborn, determined, and such

other kinds as might at times try even the patience of Job. If it were not for the mild mannered, docile kind of patient, like myself, who is willing to quietly submit to any kind of treatment that the doctor sees fit to administer without complaint, trusting that the final results may be in his favor, the doctor could be expected to be anything but genial in his social life. Giving him the benefit of the broadest point of view, and the trials and tribulations he goes through in his practise, I think he stands up fairly well as an average individual.

Now let us look at him as the General Practitioner—the family doctor. In this respect permit me to be serious for a moment—after all, judges do have their serious moments and that is the time to beware if you happen to be the subject of their thoughts as you are today. Your duty as physicians involves the practice of every virtue and the shunning of every vice. But there are certain virtues and graces of pre-eminent necessity to the physician, and certain vices and minor faults against which he must be particularly guarded. One of the former is truth. Lying is the great temptation to which physicians are exposed. When, and when should not, the physician tell his patient the truth? This is a question he must ask himself, and one, I must admit, which is difficult for him to answer. This has been made the subject of many controversies, and quite recently was the topic of a lengthy article in one of our prominent publications. You have no doubt read it so that I am not going to dwell on it to any length.

Lawyers—and I know you are going to agree with me that law is one of the most honorable of all professions—stand in professional and technical relation to veracity. The witness in the court is sworn to tell the truth, the whole truth, and nothing but the truth. The lawyer is expected to get out of the witness not exactly the truth, but a portion of the truth, and nothing but the truth—which suits him. But I do not, and I know you would not, hesitate to believe a lawyer—outside of the court room. I too have every confidence in the veracity of a doctor—outside of the sick room. I know there is nothing harder for a physician to do than to tell a lie, yet whenever he makes an unnecessary visit, he tells a lie. Whenever he writes an unnecessary prescription, he tells a lie. Whenever he tells a patient who he knows cannot possibly live, that he is coming along fine, he tells a lie. He does and says these things because he believes it to be in the interest of his patient to do so. There appears only one safe rule to follow in this respect and it is this. A physician's first duty is to his patient; his second only, to himself.

If we are to hold you in the high esteem that we should, and do, then naturally we expect you to respect your own profession. If you respect your profession as you ought, you will respect all

honored practitioners in this honored calling. By respecting them and yourselves you will avoid all degrading jealousies, and despise every unfair act which may promise to raise you at the expense of a rival. There is no profession in which teamwork is more desirable, and this the patient expects of you, particularly when he has to seek the advice of several doctors specializing in different fields of human ailments. In this respect the Tenth Commandment, with a little variation, might well be your guide. Thou shalt not covet thy neighbor's patient.

Another virtue that the patient expects you to practice is that of punctuality. There is nothing the patient appreciates more, when in extreme pain, than to have the doctor promptly respond to a call for help, even although there may be nothing he can do to relieve his suffering. Your immediate presence alone saves him a great deal of fretting, and, by the way, occasionally it will prevent him sending for your rival.

There is still one other virtue, and not the least by any means, which I think a doctor should possess, and that is humour. It is quite true that the treatment of disease is serious business, yet it is not always wise to impress a patient with the seriousness of his condition, in the alternative more progress may be made in his treatment by dispelling unnecessary fears he may have. This can best be accomplished by some humour on the part of the doctor. An eminent doctor has said: "Health and humour have always seemed inextricably bound together. The bedside manner that we hear so much about is really opening the sick-room to a merry quip, a timely jest by the medical practitioner who knows that laughter, too, is infectious."

Yes, humour is a necessary concomitant to diagnosis and treatment. Humour is the diabetes of credulous minds. It makes sugar out of human defects. It distills laughter and induces recovery. No potions, no pills, possess greater therapeutic value than humour."

It was by practicing a combination of the virtues I have just mentioned that won for many of our pioneer physicians the enviable reputations they left behind them of admirable service to mankind. After all, the final test of the service we give in any walk of life or profession is the impression we leave with those we have served after we have passed on. One of the things they will remember most is not the treatments you administered nor the operations you performed, but the humour and human kindness you displayed.

One writer clearly illustrates this by the incident he describes in these words:

"Between the laughter and the tears your doctor carries on. Into many sickrooms he brings the quip and the story that has, at times, greater therapeutic value than the medicine in his kit,

and when Old Doc himself bows out of this world he leaves behind him that same love, esteem and affection the residents of a little western town had for their Dr. Jones. This beloved old man never had the time nor desire to pile up worldly goods. On the lawn of his battered two-storied cottage was an ancient wooden sign that simply stated: Dr. Jones, Upstairs.

When old Doc Jones died there was no room for a handsome tombstone. Most of his patients were too poor to purchase one. But they had memories of him, his merry laughter, his kind humour. And so they gently uprooted the battered old sign from the lawn and placed it tenderly in his grave. It now reads: Dr. Jones, Upstairs.

You may think from what I have just said that I am not diagnosing your case to find out what conditions do exist and what character they do display, but rather setting up high hopes that I had hoped to find. If such be your thought then you are wrong for I am only using those ideals as a measuring stick to guide me in my diagnosis. I am still recognizing you as a normal individual and just as entitled to show other human tendencies due to conditions beyond your control, perhaps through suffering from chronic leucostitis with cholelithiasis, which you are as subject to as I am.

Just in case you may become too much puffed up by considering yourself endowed with all the virtues I have just enumerated and develop high hopes of leaving behind you a reputation such as the average doctor could not hope to attain, I cannot refrain from passing on to you the experience which a friend of mine recently related to me in some of his words as these:

He was suffering from an abscessed jaw due to a recent tooth extraction. He went to his favorite doctor in the hope of getting relief. He found the doctor's office full of waiting patients and the doctor therefore very busy. He was ushered into a room by the attending nurse. While waiting there in fear and trembling as to what further pain he might have to endure, he noticed a beautifully framed motto on the wall which read as follows:

"Ministering Angel, our Doctor is he
Guiding us through trial and tribulations
Ever grateful to him we shall be
Who is full of sympathy and endless patience
Like a healing salve, his hands so soothing
His steady heart and tender eyes,
A gentle voice that sounds so loving
Answering all humanity's cries.
Of life he bears the Burning Torch,
Our Doctor!"

Immediately, he said, his fears subsided, the beads of perspiration on his forehead dried, and just then the doctor walked into the room.

ordered him to open up his mouth. After a very brief examination he picked up a scalpel and for-eps and without any anaesthetic of any kind proceeded to probe into the abscess in search of some foreign material or broken piece of bone, and then left the room as quickly as he had come. As I stood there," my friend said, "with the blood oozing out of my jaw and still not recovered from the extreme pain I had endured, again I glanced up at that motto on the wall, and particularly at those words "his hands so soothing," and I can assure you, never before did that motto come so near to being taken down and thrown out on the street."

He may have had somewhat the same feeling as Eddie Cantor did when he said:

"One thing that burns me up in a hospital is when several doctors get together in a corner of our room for a consultation. They mumble—look at you—turn away—take another look—and go into a huddle again. One day when this happened, I stared at them, and you know I have got something to stare with. They left the room and continued their talking in the hall. I got out of bed, tiptoed over to the door and listened. You know something? They were planning a big party for the following Saturday night, and I have a feeling that I'm the party who was paying for the party."

Now I fear my time is up so I will have to refrain from dealing with the other doctor relationships I have referred to, much as I would like to go so.

However, at the risk of boring you, I might add this further observation, before closing. In recent years there has been a marvelous advance in medical science, no doubt perhaps, as a result of the last world war. New drugs have been discovered, and new techniques developed. One notable change in methods of medical practise has been the development of medical clinics. Doctors have apparently found it advisable to unite their efforts by forming groups of doctors, no doubt with the intention of rendering better service to their patients. I do not question your good intentions in this respect, and the possible benefit to the patient, but again let me remind you that I am looking at you from the point of view of the patient who no doubt wonders if it is essential to go through a clinic to be assured that he is getting complete diagnosis, and the best kind of treatment, or will the services of the family doctor, he has depended on for years, meet his needs.

Years ago the farmer threshed his grain with a flail. It was a slow and laborious procedure. But he got the grain, and no doubt all of it. Then was gradually developed the intricate threshing ma-

chine as we have it today, with all of its component parts of wheels, cylinder, belts, nuts, screws, etc. This gets the job done quicker, and with less manual labor, and the final result is the threshed grain, as with the flail. The manufacturers of threshing machinery, and the salesman who sells it, has been able to prove to the farmer, apart from the speed of the operation, that he is getting a better job done. Is he, or is he just getting satisfaction out of watching this machinery work, and bouncing his grain around a little more.

The more doctors who look us over, and the more we are examined and pushed around from one doctor to another, cannot help but impress us by the service, or at least the attention, we are getting, but as to the final results in comparison with the old system, we are unable to judge. Only a doctor can do that. We at least get a kick out of boasting that we have gone through a clinic. But time alone will tell if it is giving us a greater kick, and more kicks, out of life.

When the old model T-Ford balked on the road we could, without much knowledge of cars, get out, take it apart, put it together again, add a few strands of barbed wire, and then go on our way and finally reach our destination.

When the car of today, with all of its intricate machinery, and confusing electric wiring stops on us, we are beat, and have to sit on side of the road for an expert to come and fix it. I wonder if they did not introduce these new fangled gadgets so we would need the aid of an expert.

However we do boast about our new car, and all of its fancy trimmings, high powered engine, and intricate interior, even if we have no knowledge of how it works and is put together, and are proud of the speed at which we travel, even if we may eventually be longer in arriving at our destination. The important thing is that we appear to be better satisfied by having all of these new fangled ideas working for us.

Doctors tell us that the secret of good health, and quick recovery from disease is happiness and satisfaction. If the clinic gives us at least this, then it is worth while.

So there is my diagnosis, but not being a doctor nor a psychiatrist, I cannot prescribe the remedy. You being doctors, I leave it to you to find the cure for any defects I may have found.

I will therefore end this exhortation with the words of Dr. Oliver Wendell Holmes when closing his address to a graduating class of medical students:

"It is time to bring these hurried and crowded remarks to a close. Reject what in them is false, examine what is doubtful, remember what is true; and so, God bless you, gentlemen, and farewell."

Civil Defence Health Planning

Reported by H. Malcolmson

Dr. K. C. Charron of the Civil Defence Health Services Planning Group in Ottawa, visited Winnipeg during November and met with members of the Hospital, Medical, Dental and Nursing Associations and the Civil Defence Staffs of the Provincial Government and the Metropolitan Board (Greater Winnipeg).

To them he outlined an action programme designed to ensure the development and actual organization of first aid and casualty treatment facilities around all the target areas in Canada.

Insofar as Manitoba is concerned it has been agreed that attention should be focused upon the development of about eighteen first aid teams around the centre of Winnipeg. Initially one team will be developed in each of the six pie-shaped zones into which the Metropolitan Civil Defence Board has divided Greater Winnipeg. Later the total in each zone will be increased to three.

Each first aid team, according to Canadian planning, will consist of Four Physicians, Three Dentists, Six Nurses and Sixty Helpers. In setting up the posts, however, it is suggested that the professional establishment be increased by fifty per cent to allow for casualties of various sorts. It will be seen the implementation of these plans will require the participation of about 100 doctors, 90 dentists, 160 nurses and about 1,500 trained volunteers. Dr. S. A. Boyd, President of the Winnipeg Medical Society, has set up a committee to commence the implementation of this important phase of the Civil Defence Planning.

The casualty treatment and hospital organization phases of the plan are closely inter-related. Dr. W. R. Dunlop of Deer Lodge Hospital, has been designated as the Civil Defence representative of the Associated Hospitals of Manitoba. In close liaison with the Medical Society his group is initiating studies of the casualty treatment capacity of the Greater Winnipeg hospitals.

Similar Canadian Targets are planning for the development facilities to provide hospitalization for about 10,000 persons. It is therefore quite evident that secondary or emergency hospital facilities will be needed around the Greater Winnipeg area. This phase has not as yet been studied in detail but it is pictured that facilities might be organized at such institutions as the Normal School, Tuxedo; the University of Manitoba, Fort Garry, and possibly the Selkirk Mental Hospital.

The important place of personnel and facilities outside Winnipeg will shortly be studied intensively. Medical men, it is pictured, will be organized through these district medical societies in such a way that each has an exact function to carry out should disaster occur. Three major roles

are pictured at the present time:

(1) The relief of first aid post and casualty treatment teams in Greater Winnipeg.

(2) The care of casualties evacuated to hospitals outside Greater Winnipeg.

(3) Membership in mobile teams of Physicians and nurses, representing a standard "Dakota" unit for dispatch to disaster areas anywhere on the continent.

The matter of age groups and military categories of participating physicians has received considerable discussion. It has been agreed for purposes of getting the "action plan" underway, all groups should be called upon irrespective of military status. Once the plan has been translated from paper to actuality consideration must be given to the removal of persons in military categories from key positions.

First Aid and Home Nursing, Greater Winnipeg

St. John Ambulance have been requested by the Greater Winnipeg Civil Defence Board to teach the "Basic" (8 hour) first aid course to about 100 volunteers during January, February and March. St. John plan to operate 15-20 classes of approximately 100 persons each concurrently using qualified St. John Ambulance instructors.

Outside Greater Winnipeg

It is obvious that the evacuation of large numbers of casualties from Greater Winnipeg to hospitalized cities and towns of Manitoba will create tremendous "volunteer" staff problems. It is felt that all such communities should seriously consider the development of local facilities of individuals trained in the simple phases of nursing and first aid. Assistance in the planning and conduct of such courses is being offered both St. John Ambulance and the Manitoba Red Cross. Local physicians, it is felt, can do much to stimulate interest and activity in this important work.

The medical phases of Civil Defence are staggering in dimension and the problems presented themselves can rarely be solved by precedent. All who had the opportunity of seeing Dr. Charron during his recent visit were impressed with the sound and orderly way in which Canadian Planning has been carried out. The related professional organizations have been represented in the many working parties in Ottawa and the "action plan" bears the approval of all organizations.

In translating this plan from paper to action great reliance is being placed upon the Medical, Dental, Hospital and Nursing Associations at the local level. Success will depend wholly upon the degree and quality of participation that is received.

H. Malcolmson

Medico-Literary

J. C. Hossack, M.D., C.M. (Man.)

Death of Charles II

Scarcely had Charles risen from his bed when his attendants perceived that his utterance was indistinct, and that his thoughts seemed to be wandering. Several men of rank had, as usual, assembled to see their sovereign shaved and dressed. He made an effort to converse with them in his usual gay style; but his ghastly look surprised and alarmed them. Soon his face grew black; his eyes turned in his head; he uttered a cry, staggered, and fell into the arms of one of his lords. A physician who had charge of the royal tortois and crucibles happened to be present. He had no lancet; but he opened a vein with a pen-knife. The blood flowed freely; but the King was still insensible.

He was laid on his bed, where, during a short time, the Duchess of Portsmouth hung over him with the familiarity of a wife. But the alarm had been given. The Queen and Duchess of York were hastening to the room. The favourite concubine was forced to retire to her own apartments. Those apartments had been thrice pulled down and thrice rebuilt by her lover to gratify her caprice. The very furniture of the chimney was of massy silver. Several fine paintings, which properly belonged to the Queen, had been transferred to the dwelling of the mistress. The sideboards were piled with richly wrought plate. In the niches stood the cabinets, the masterpieces of Japanese art. On the hangings, fresh from the tapestries of Paris, were depicted, in tints which no English tapestry could rival, birds of gorgeous plumage, landscapes, hunting matches, the lordly terrace of Saint Germain, the statues and fountains of Versailles. In the midst of this splendour, purchased by guilt and shame, the unhappy woman gave herself up to an agony of grief, which, to do her justice, was not wholly selfish.

And now the gates of Whitehall, which ordinarily stood open to all comers, were closed. But persons whose faces were known were still permitted to enter. The antechambers and galleries were soon filled to overflowing; and even the sick room was crowded with peers, privy councillors, and foreign ministers. All the medical men of note in London were summoned. So high did political animosities run that the presence of some Whig physicians was regarded as an extraordinary circumstance. One whose skill was then widely renowned, Doctor Thomas Short, was in attendance. Several of the prescriptions have been preserved. One of them is signed by fourteen doctors. The patient was bled largely. Hot iron was applied to his head. A loathsome volatile salt,

extracted from human skulls, was forced into his mouth. He recovered his senses; but he was evidently in a situation of extreme danger.

The Queen was for a time assiduous in her attendance. The Duke of York scarcely left his brother's bedside. The Primate and four other Bishops were then in London. They remained at Whitehall all day, and took it by turns to sit up at night in the King's room. The news of his illness filled the capital with sorrow and dismay. For his easy temper and affable manners had won the affection of a large part of the nation; and those who most disliked him preferred his unprincipled levity to the stern and earnest bigotry of his brother.

On the morning of Thursday the fifth of February, the London Gazette announced that His Majesty was going on well, and was thought by the physicians to be out of danger. The bells of all the churches rang merrily; and preparations for bonfires were made in the streets. But in the evening it was known that a relapse had taken place, and that the medical attendants had given up all hope. The public mind was greatly disturbed; but there was no disposition to tumult. The Duke of York, who had already taken on himself to give orders, ascertained that the city was perfectly quiet, and that he might without difficulty be proclaimed as soon as his brother should expire.

The King was in great pain, and complained that he felt as if a fire was burning within him. Yet he bore up against his sufferings with a fortitude which did not seem to belong to his soft and luxurious nature. The sight of his misery affected his wife so much that she fainted, and was carried senseless to her chamber. The prelates who were in waiting had from the first exhorted him to prepare for his end. They now thought it their duty to address him in a still more urgent manner. William Sancroft, Archbishop of Canterbury, an honest and pious, though narrowminded man, used great freedom. "It is time," he said, "to speak out; for, Sir you are about to appear before a Judge who is no respecter of persons." The King answered not a word. . . .

It was now late in the evening. The King seemed much relieved by what had passed. His natural children were brought to his bedside, the Dukes of Grafton, Southampton and Northumberland, sons of the Duchess of Cleveland, the Duke of Saint Albans, son of Eleanor Gwynn, and the Duke of Richmond, son of the Duchess of Portsmouth. Charles blessed them all, but spoke with peculiar tenderness to Richmond. One face which should have been there was wanting. The eldest

and best beloved child was an exile and a wanderer. His name was not once mentioned by his father.

During the night Charles earnestly recommended the Duchess of Portsmouth and her boy to the care of James; "And do not," he good-naturedly added, "let poor Nelly starve." The Queen sent excuses for her absence by Halifax. She said that she was too much disordered to resume her post by the couch, and implored pardon for any offence which she might unwittingly have given. "She ask my pardon, poor woman!" cried Charles; "I ask hers with all my heart."

The morning light began to peep through the windows of Whitehall; and Charles desired the attendants to pull aside the curtains that he might have one more look at the day. He remarked

that it was time to wind up a clock which stood near his bed. These little circumstances were remembered. . . . He apologized to those who had stood round him all night for the trouble which he had caused. He had been, he said, the most unconscionable time dying; but he hoped that they would excuse it. This was the first glimpse of that exquisite urbanity, so often found potent to charm away the resentment of a just and incensed nation. Soon after dawn the speed of the dying man failed. Before ten his senses were gone. Great numbers had repaired to the church at the hour of morning service. When the prayer for the King was read, loud groans and sobs showed how deeply his people felt for him. On noon Friday, the sixth of February, he passed away without a struggle.

—Macaulay, "History of England"

Book Reviews

Text Book of Anatomy

To doctors the names "Cunningham" and "Anatomy" are synonyms. It is probable that, throughout the English-speaking world, more students have used the famous Text Book than all other works on anatomy combined. Now, after an existence of half a century there is a new edition.

Daniel John Cunningham was born a little over a century ago (1850). Fifty years later he conceived the plan of his text book. In its preparation he associated with himself a number of other anatomists all of whom had been students of Sir William Turner. Thus, in a way, the Text Book perpetuated the name and teachings of the great anatomist and was also a tribute to his memory.

In like manner the editor of the present edition, Professor J. C. Brash, has students of Cunningham as his collaborators and thus they in turn, in this new edition, pay tribute to their master on the centenary of his birth. The co-authors of the work are eminent anatomists attached to the Universities of Edinburgh, London, Oxford, Leeds, St. Andrews, Aberdeen, Wales, Cape Town, McGill and Toronto. Professor C. Boileau Grant who once filled the Chair of Anatomy here contributes the section on the Respiratory System.

The new Cunningham reveals anatomy as a living subject, capable of advance and change. It is unique in that it supplies a bibliography with many references to the work of new as well as of classical authorities. Thus the most recent advances in the oldest of professional studies are incorporated in this newest of texts. Another "living" aspect is shown by photographs of muscles in action. From these the student learns to recog-

nize the structures which underlie the contours of the living body.

Much reliance is placed upon, and much is given by, illustrations of which there are 1,252 in the text and more than half of these are in color. In addition there are 88 plates representing separate radiographs as well as the illustrations of muscles in action mentioned before. All these aids (there are tables as well) make the study of anatomy more interesting, and therefore easier for the student.

But while "Cunningham" is a necessity for undergraduates it is scarcely less needful for postgraduates especially those who do surgery.

Many surgeons refer frequently to the text book purchased when students and continue to use it on the assumption that anatomy does not change. But it does change and so, also does the method of its presentation. Those who still use the earlier editions and find them useful might well consider replacing their old friend with its latest descendant. The help they will receive therefrom may not be less but greater.

Cunningham's Text Book of Anatomy, edited by James Couper Brash, M.C., M.A., M.D., F.R.C.S. Ed., F.R.C.E. Professor of Anatomy, University of Edinburgh, 9th Edition, 1,624 pages. Illustrated by 1,252 text figures, 699 of which in color, and 88 plates including 145 radiographs. Geoffrey Cumberlege, Oxford University Press, Toronto, 1951. Price \$16.25.



Treatise on Surgical Infections

By Frank Lamont Meleney, M.D., Associate Professor of Clinical Surgery, College of Physicians and Surgeons, Columbia University; Associate

Visiting Surgeon, Presbyterian Hospital, New York. 9¼ x 6 inches. Pp. 713 and xvi with numerous illustrations, 1948. New York, Oxford University Press. \$15.00.

Meleney's book is the most comprehensive and authoritative volume upon the subject of surgical infections. It represents the labors of twenty-five years and publication was delayed so that the actions and effects of the newer remedies might be properly evaluated. Its 700 pages contain practically everything that is known about the subject. A. O. Whipple, in his Introduction, has this to say: "Since Lister's time no surgeon has studied so intensively, and has made so many original contributions to, the subject of the bacteriology of infection and inflammation requiring surgical therapy as has Dr. Meleney in the past 25 years."

The book begins with the historical aspects of infection, especially with the epoch-making work of Pasteur and Lister, whereby the aim of uninfected operative wounds has been made possible for all surgeons. Chapters are devoted to the classification of infections, the sources of contamination of surgical wounds, and how contamination can be prevented. The problems and methods of sterilization are considered fully including the use of ultra-violet rays for air sterilization.

The actions and uses of antiseptics and disinfectants are dealt with quite fully by E. J. Pulaski.

The causes of infection in clean operative wounds are given full consideration and the merits of various nature materials are discussed.

Two chapters on bacteriology are contributed by bacteriologists of the Presbyterian Hospital. This is a very full and necessary contribution.

How bacteria manage to invade the body and what happens afterwards form the subject matter of several chapters. These cover the problems of invasion, establishment by the invaders, the marshalling of defence and the defensive mechanisms.

Following are chapters on treatment—the surgical principles involved and the actions, and uses of chemo-therapeutic and anti-biotic agents. Included here are considerations of bacitracin (developed in Meleney's laboratory) and hydrogen peroxide which he finds of great value in chronic undermining ulcers.

The book is so complete that no aspect of the subject is omitted and all aspects are covered thoroughly.—M. L.

The Canada Year Book, 1951

"Canada and All About It" would form a fitting subtitle for this work. Within its twelve hundred pages one will find an answer to any of innumerable questions about the Dominion. It is the official source of authentic information about the country wherein we live and work.

The Year Book synthesizes all the important reports and publications of federal and provincial governments; it summarizes and co-ordinates statistics of physiography, demography, health, welfare, education, labour, national income, resources, production, trade, transportation, communications, finance—in fact, of every important subject that has a bearing on the national economy.

Special features of current interest are included and the regular chapter material brought up to date. The reorganization of the Department of Mines and Resources during 1950 and the transfer of its administrative functions to three new Departments—the Department of Mines and Technical Surveys, the Department of Resources and Development, and the Department of Citizenship and Immigration—necessitated revised treatments in the corresponding sections of the Year Book. The part dealing with citizenship is introduced by material on early naturalization procedure and events leading up to the Canadian Citizenship Act.

The production chapters (XI to XVIII) continue the story of steady expansion in the primary industries and of outstanding development in the industrial field.

While the chapters deal with the respective subjects in detail, the introduction to the current edition serves to highlight the major events of the year and presents to the reader a picture of the national economy as a whole.

Numerous maps and charts are included which bring into focus developments indicated by the figures.

To permit of the introduction of as much new material as possible, references to earlier editions are given for standard material that has not changed significantly. It is a volume of daily usefulness and when the reader merely turns over the pages out of curiosity it is amazing how interest grows as new facts are acquired.

The Year Book will reveal to the new reader a Canada he never knew before.

The Canada Year Book, 1951, Ottawa, the King's Printer. Price \$3.00.

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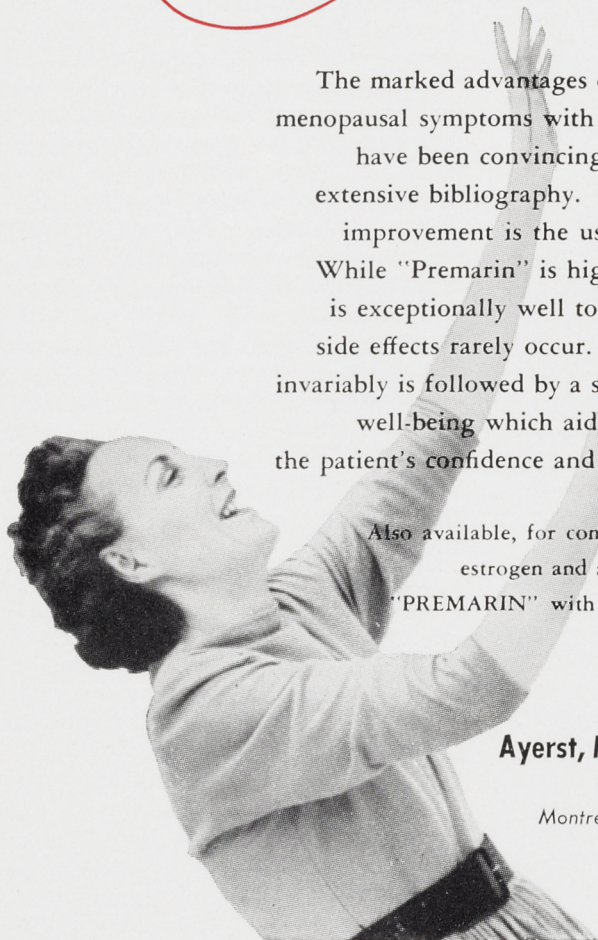
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Social News

Reported by K. Borthwick-Leslie, M.D.

Major Allan M. Davidson left a week ago for Korea, having been posted to a Field Surgical Team. The position is listed for one year's duration. Happy landings, Allan, and the very best of good luck associated with interesting surgical experience.

Dr. F. A. Benner has been honored by re-election as President of the United Empire Loyalists Association of Canada, Winnipeg Branch.

Dr. and Mrs. Arnold Stobart, Carman, Man., announce the engagement of their only daughter, Isabelle Anne, to Mr. Eric Gordon Reed, of Winnipeg. The wedding will take place March 1 in Carman United Church.

The meeting of the Winnipeg Medical Society, last month, held at Deer Lodge Hospital, was meticulously prepared and displayed. The staff deserves a great deal of credit. Particularly entertaining was the "Vasorube" display, clever wit! I rather objected to being paged by one member to inspect what he said would be a typical item for my "Gossip Column" labelled as "Back from Korea," one of the largest, ugliest pickled Round Worm one could imagine.

News from my "Groaners Club" is not very active these days, but it is a pleasure to welcome Dr. W. M. Musgrove (Bud) back into circulation, and his work at Deer Lodge Hospital after some months of forced rest. Dr. Washington has been on the groaning list again, as a matter of fact believe he is still grouching a bit but improving. There must be numerous other members of the club but have had no further reports.

My local "Grape Vine" reports that our old friend, Dr. Adam Menzies, Morden, Man., has been very ill, but is now recovering satisfactorily. Congratulations I believe are also in order to Dr. Menzies on the birth of his grandson. The new arrival is the son of Dr. and Mrs. Jas. Menzies, Morden, where Jimmie is his father's partner and assistant.

Dr. and Mrs. David J. Shapiro are happy to announce the birth of their daughter, Sheila Faye, Jan. 27th.

Dr. and Mrs. Glen Willson, Flin Flon, Man., announce the arrival of Christopher Blake, junior brother for Mark and David.

In the Ball Memorial Hospital, Muncie, Indiana, Sarah Jane Montgomery appeared on Jan. 5, daughter of Dr. and Mrs. Lall G. Montgomery.

Dr. and Mrs. G. R. Diehl, Niagara St., are being congratulated on the birth of their son, Kevin Ferguson.

Congratulations to another grandfather! Born to Mr. and Mrs. J. F. McGuinness (son of Dr. Fred), a son, Frederick Micheal, on Feb. 4, 1952, Grampa Fred surely has developed a gleam in his eyes these days. I wondered why!

In Toronto, Mr. and Mrs. Donald C. Archibald (nee Dr. Marguerite Swan), announce the arrival of Merrin Margaret, Jan. 12, baby sister for Janet, Stuart and Ian.

I have been chastised because of lack of news from our Rural Members. What about it? Why not keep me posted?

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I. Hunter, R.B., and Dunlop, D.M.: Quart. J. Med.,
17: 271-290, 1948

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Editorial

J. C. Hossack, M.D., C.M. (Man.), Editor

The 1952 Convention

Contributions are now being requested for the Scientific Programme. Those who contemplate taking part are reminded of the rules governing the acceptance of contributions:

1. Speakers are limited to twenty minutes each, and ten minutes will be allowed for discussion. (It may be helpful to remember that one standard-size sheet of double-spaced typescript requires three minutes of time for careful, uninterrupted delivery, or two and a half minutes if spoken fairly quickly and without interruption. That is, a twenty-minute presentation should not exceed eight pages of typescript).

2. All contributors will be expected to submit their typescripts to the Review for possible publication.

The dead line for the receipt of communications will be published next month.

February — The Month

In very ancient time the year began (as in some places it still does) in the Season of Spring and in the month we now call March. There were then but ten months. Numa Pompilius, the second King of Rome, disturbed this arrangement by adding two new months—January and February.

February has been a very ill-used month. First of all Numa himself laid upon it the doom—the inevitable fate of some one of the months—of sacrificing one of its days every three years out of four. Then when Augustus decided to adopt and rename Sextilis, he decided also to increase its dignity by increasing the number of its days from thirty to thirty-one. And it was from the already truncated February that he took his extra day. Since then no one has thought to increase its length and so it "hath twenty-eight days clear, and twenty-nine in each leap year."

The name "February" was given by Numa to this new month because early in it the Romans performed certain rites of expiation and purification (februare—to expiate, to purify)—and this ancient custom has persisted into the Christian era.

The second day of February is celebrated in both the Roman and Anglican Churches as the

Feast of the Purification of the Virgin. The popular name given to this festival—Candlemas—is derived from the ceremony which the Church of Rome dictates to be observed on this day, namely the blessing, distribution and lighting of candles.

The origin of Candlemas is thus described in Brand's "Observations on popular Antiquities."

"Pope Sergius," says Becon in his *Reliques of Rome* (1563), commanded "that all people 'shuld go on procession upon Candlemas Day, and carry Candels about with them brenning in their hands in the year of our Lord, 684.'"

How this candle-bearing on Candlemas Day came first up, the author of "Our English Festivals" explains in this manner:

"Somtyme, when the Romaines by great myght, and royal power, conquered all the world, they were so proude that they forgat God, and made them diuers gods after their own lust. And so among all they had a god that they called Mars, that had been tofore a notable knight in battayle; and so they prayer to hym for help, and for that they would speed the better of this knight, the people prayed and did great worship to his mother, that was called Februa, after which woman much people have opinion that the moneth is Candlemas called. Wherefore the second daie of thys moneth is Candlemas Day. The Romaines this night went about the City of Rome with torches and cand'les brenning in worship of this woman Februa, for hope to have the more helpe and succoure of her sonne Mars.

Then there was a Pope that was called Sergius; and, when he saw Christian people draw to his false maumerty and untrue belief, he thought to undo this foule use and custom, and turn it unto God's worship and our Lady's, and gave commandment that all Christian people should come to church and o'fer up a Candle brennyng, in the worship that they did to this woman Februa, and do worship to our Lady and to her sonne our Lord. So that now this Feaste is solemnly ha'llowed thorowe all Christendome. And every Christian man and woman of covenable age is bound to come to church and offer up their Candles, as though they were bodily with our Lady, hoppyng for this reverence and worship that they do to our Ladye to have a great rewarde in Heaven." And it is added: "A Candell is of weke and wexe; so was Crystes soule hyd within the manhede: also the fyre betokeneth the Godhede: also it betokeneth our Ladyes moderhede and maydenhede, lyght with the fyre of love."



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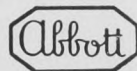


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Association Page

Reported by M. T. Macfarland, M.D.

Income Tax Information

Individuals whose income—(a) is derived from carrying on a business or profession (other than farming); (b) is derived from investments; or (c) is more than 25% derived from sources other than salary or wages, are required to pay their estimated tax by quarterly instalments during such year. Each payment must be sent in with Instalment Remittance Form T.7-B Individuals. Any balance of tax is payable with interest with the T.-1 General return which is due to be filed on or before April 30 of the succeeding year.

The following timetable indicates the returns required.

A. Doctors **Not** receiving salaries amounting to ¾ of income:

Date Due	Forms to be Used
March 31	T.7-B Individuals
April 30	T.1 General
(Note: Only doctors deriving their full professional income from salaries may use Form T.1 Short).	
June 30	T.7-B Individuals
September 30	T.7-B Individuals
December 31	T.7-B Individuals

B. Doctors receiving salaries amounting to ¾ or more of income:

Date Due	Forms to be Used
April 30	T.1 General
(Note: Doctors deriving their full professional income from salaries may use Form T.1 Short).	

Whenever Status is changed* T.D.-1.

Doctors who pay salaries to their own employees are required to send in Form T.-4 by the end of February each year.

DOMINION INCOME TAX RETURNS
BY MEMBERS OF THE MEDICAL PROFESSION

As a matter of guidance to the medical profession and to bring about a greater uniformity in the data to be furnished to the Taxation Division of the Department of National Revenue in the annual Income Tax Returns to be filed, the following matters are set out:

Income

1. There should be maintained by the doctor an accurate record of income received, both as fees from his profession and by way of investment income. The record should be clear and capable of being readily checked against the return filed. It may be maintained on cards or in books kept for the purpose.

*With respect to new employer, marital status, dependents.

Expenses

2. Under the heading of expenses the following accounts should be maintained and records supported by vouchers kept available for checking purposes:

- (a) Medical, surgical and like supplies;
- (b) Office help, nurse, maid and bookkeeper; laundry and malpractice insurance premiums. (It is to be noted that the Income Tax Act does not allow as a deduction a salary paid by a husband to a wife or vice versa. Such amount, if paid, is to be added back to the income);
- (c) Telephone expenses;
- (d) Assistants' fees: The names and addresses of the assistants to whom fees are paid should be furnished. This information is to be given each year on Income Tax form known as Form T.4, obtainable from your District Income Tax Office;
- (e) Rentals paid: The name and address of the owner (preferably) or agent of the rented premises should be furnished (see (i));
- (f) Postage and stationery;
- (g) Depreciation: A description of the treatment of depreciation may be found on page four of the Income Tax Return form T.1 General under the Part XI Method.

The method of computing depreciation for tax purposes is the same as that used last year and you should have no difficulty if you have a copy of last year's return available.

Simply carry forward the balance remaining in each class after deducting last year's allowance. Add to this figure the cost of any new equipment purchased and deduct the proceeds from any disposal of property in each class. The rate you wish to use not exceeding the maximum rate (see below) is applied to this new balance for each class to obtain the depreciation you may claim this year.

The schedule on page four of the Income Tax Return is reproduced below for your information. Column (6) does not apply to doctors, the other columns are self-explanatory.

The maximum rates for the classes of equipment most used by doctors follow:

Capital Item	Annual Maximum Class Depreciation
Medical Equipment:	
(a) Instruments Costing over \$50 Each and Medical Apparatus of Every Type	8 20%
(b) Instruments Under \$50 Each	12 100%
Office Furniture and Equipment ..	8 20%
Motor Car	10 30%
Building (Residence Used Both as Dwelling and Office)	3 5%

Instruments costing less than \$50.00 each belong in class 12 and have a maximum allowance rate of 100%. They should not be included in expenses but should be recorded as additions in column 3 of the schedule.

Where a doctor practises from a house which he owns and resides in, the allowance may be claimed as above on a portion of the cost of the residence, excluding land. For example if the residence were a brick building costing \$12,000 and one-third of the space were used for the office, the doctor would use \$4,000 as the business portion of the cost and apply the building rate of 5% to determine the maximum depreciation allowable in the first year.

For further information on the subject you may refer to the Regulations or you may consult your District Income Tax Office.

Schedule

(1) Class Number	(2) Undepreciated Capital Cost at Beginning of 1951 (Col. 10 of 1950 return)	(3) Cost of Additions During 1951	(4) Proceeds from Dis- posals During 1951	(5) Undepreciated Capital Cost before 1951 Allow- ance (Col. 2 plus 3, less 4)	(6) Net Defer- red Assets	(7) Amount on which 1951 Allowance is Calculated (Col. 5 less Col. 6)	(8) Rate %	(9) Capital Cost Allowance for 1951	(10) Undepreciated Capital Cost Less Deferred Assets (Col. 5 less Col. 9)
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(h) Automobile expense; (One Car). This account will include cost of license, oil, gasoline, grease, insurance, garage charges and repairs;

The capital cost allowance is restricted to the car used in professional practice and does not apply to cars for personal use.

Only that portion of the total automobile expense incurred in earning the income from the practice may be claimed as an expense and therefore the total expense must be reduced by the portion applicable to your personal use.

The mileage rate permitted in years prior to 1950 may no longer be used to estimate the automobile expenses.

(i) Proportional expenses of doctors practising from their residence:

(a) Owned by the doctor. Where a doctor practises from a house which he owns and as well resides in, a proportionate allowance of house expenses will be given for the study, laboratory, office and waiting room space, on the basis that this space bears to the total space of the residence. The charges cover taxes, light, heat, insurance, repairs, capital cost allowance, and interest on mortgage (name and address of mortgagee to be stated);

(b) Rented by the doctor. Only the rent and other expenses borne by the doctor such as heat and light will be apportioned inasmuch as the owner takes care of other expenses.

The above allowances will not exceed one-third of the total house expenses or rental unless it can

be shown that a greater allowance should be made for professional purposes.

(j) Sundry expenses (not otherwise classified)—The expenses charged to this account should be capable of analyses and supported by records.

Claims for donations paid to charitable organizations will be allowed up to 10% of the net income upon submission of receipts to your Income Tax Office. This is provided for in the Act.

The annual dues paid to governing bodies under which authority to practise is issued and membership association fees, to be recorded on the return, will be admitted as a charge. Initiation fees and the cost of attending post-graduate courses will not be allowed.

(k) Carrying charges: The charges for interest paid on money borrowed against securities pledged as collateral security may only be charged against

the income from investments and not against professional income.

(1) Business tax will be allowed as an expense but Dominion, Provincial or Municipal income tax will not be allowed.

Convention Expenses

"Effective January 1, 1948, the reasonable expenses incurred by members of the medical profession in attending the following Medical Conventions will be admitted for Income Tax purposes against income from professional fees:

1. One Convention per year of the Canadian Medical Association.

2. One Convention per year of either a Provincial Medical Association or a Provincial Division of the Canadian Medical Association.

3. One Convention per year of a Medical Society or Association of Specialists in Canada or the United States of America.

The expenses to be allowed must be reasonable and must be properly substantiated; e.g., the taxpayer should show (1) dates of the Conventions; (2) the number of days present, with proof of claim supported by a certificate of attendance issued by the organization sponsoring the meetings; (3) the expenses incurred, segregating between (a) transportation expenses, (b) meals and (c) hotel expenses, for which vouchers should be obtained and kept available for inspection.

None of the above expenses will be allowed against income received by way of salary since such deductions are expressly disallowed by statute."

Professional Men Under Salary Contract

The employees' annual contribution to an approved Pension Plan and alimony payments may be deducted from salary income.

Amendments to the Income Tax Act, introduced in 1951 and made retroactive to the beginning of the calendar year 1951, provide for the deduction of certain expenses from salary income.

The allowable expenses include travelling expenses, annual professional membership dues, office rent, salary to an assistant or substitute and supplies consumed directly in the performance of the duties of employment.

The annual registration fee of the Provincial medical licensing authority would be allowable if paid by the doctor himself.

Certain conditions are attached to the allowance of the expenses and without trying to recite the exact provisions of the law the main points are:

(a) That the expenses must have been incurred in the performance of the duties of the office or

employment.

(b) That the employee is required, under the contract of employment, to pay the expenses.

(c) To claim travelling expenses the employee must be ordinarily required to carry on the duties of his employment away from his employer's place of business. Travelling between the doctor's home and his office is not included.

Where the travelling expenses are allowable under these provisions, depreciation may be claimed on the automobile used for this purpose but no other claim for depreciation may be made.

Income From a Partnership

Additional expenses incurred by a partner, but not charged to the partnership, may be claimed as a deduction from the partner's share of income. However, the partner must be in a position to substantiate these expenses, to show why they were not charged directly to the partnership and that they were necessarily laid out to earn the partnership income.

Manitoba Hospital Service Association

The Pre-Existing Condition Clause

In dealing with a common fund, many people will conduct themselves in a manner which in dealing with their neighbors they would regard as stealing.

For this reason, all insurance funds, whether life, casualty or health, have had to adopt controls against abuse. These protect the fund; they are to the ultimate advantage of the policy-holder. In applying for insurance, the prudent man asks what assurance have I that the premium is the minimum necessary to meet all legitimate claims. He examines the contract provisions which prevent the insurance fund being victimized. If these are adequate, he knows his money will not be wasted.

The Pre-existing Condition Clause in the Manitoba Hospital Service Association is a control against a flagrant abuse.

Be it remembered that, if Blue Cross is to serve the hospital care needs of the whole population, those with existing health impairments must be enrolled. Their exclusion would only add oil to the flames of agitation for Government compulsory health insurance. The Clause then operates within the framework of sound underwriting percentage enrolment regulations. In some instances it can be waived altogether.

What is required is a contract provision preventing individuals from joining when they learn

they need hospital care, having the required operation, then terminating.

The Clause then reads:

"Hospital service for any condition, disease or ailment which existed on the acceptance date of the subscriber's contract or for which medical or surgical treatment or advice has been rendered within one year prior to such acceptance date shall be available to a subscriber only after the expiration of one year from such acceptance date."

Its value to the existing membership is obvious; it is also important in "sales" and in promoting continuity of membership. For the latter reason particularly, it is featured in presentations of the service to prospective groups.

The Clause gives contract protection. In addition to this, other insurance funds have found more is necessary. Where other classes of insurance are protected by law against abuse; Blue Cross depends on the doctors.

**By-Law on
Specialist Register
See Page 123**

It's the Exception that proves the rule.



Fortunately not all babies are alike — and although "Farmer's Wife" No.'s 1 and 2 are most widely used, the fact remains that for some babies it is advisable to use a skimmed milk formula.

"Farmer's Wife" No. 3 (Yellow Label) has provided a concentrated skimmed milk of consistent composition and high quality that can be used by the mother without any change in the methods of formula preparation.

YELLOW LABEL

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Butterfat 2%, Total Milk Solids 22%, Calories per oz. 29

"Farmer's Wife" No. 1 (Red Label) — Whole Milk

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Winnipeg Medical Society

Reported by Murray Campbell

The regular monthly meeting of the Society was held Friday, December 14th, and was featured by a Symposium on Arthritis. The Chairman was Dr. R. McFarlane and other members of the panel were Doctors R. Tucker, S. Rusen, J. C. Wilts and Miss E. M. Danard, chief physiotherapist at Deer Lodge Hospital. Dr. McFarlane said that to the physician arthritis means one of a variety of different diseases affecting joints and to the patient it denotes what the physician knows as chronic crippling rheumatoid arthritis. This is important because when the word arthritis is used the patient considers that it only refers to chronic rheumatoid arthritis with its crippling affect and he is not by nature an optimist. It is very important therefore to make a correct diagnosis.

Dr. J. C. Wilts of the Department of Pathology discussed laboratory procedures in rheumatoid arthritis. For our purpose the procedures may be grouped as shown on the chart. The first group includes the common procedures that are done in the general investigation of a patient with rheumatoid arthritis. These tests contribute much more to the welfare of the patient than any of the others. It might be pointed out at this stage that despite all the work done on laboratory procedures, there is no absolutely diagnostic test of rheumatoid arthritis. It is fortunate that the diagnosis is not a problem in most cases.

The E.S.R. and white blood count aid in differentiating early rheumatoid arthritis from the common fleeting arthralgias and myalgias; they also help in predicting the onset of exacerbations and remissions and in assessing the significance of the numerous complaints that some of these patients have.

Dr. S. Rusen discussed the medical treatment and stated that for scientific purposes and also for the standardization the reports of different workers, the American Rheumatism Society has formulated "Therapeutic Criteria in Rheumatoid Arthritis." In following these criteria one estimates the progress of a patient by observing the objective findings only—systematic effects, fever, sedimentation rate, blood count, signs of inflammation of the joint, mobility of the joint, and so on. For accurate work the subjective evidence has had to be ignored. Human beings are not test tubes and they vary immeasurably in their suggestibility and their ability to stand pain and their will power to keep going. For some patients the relief of pain constitutes major improvement and these people do not care if they have continued signs which show that they are really no better at all. It is certainly our purpose to make the patient feel better but we should not consider

them actually improved unless it can be demonstrated objectively.

Unless these criteria are the sole basis for computing results of treatment, results will be equivocal and progress hindered. As an example of what can happen one may note the recent flurry about D.O.C.A. and vitamin C. Within about a year after this treatment was proposed there were ten articles reporting favorable results and ten more finding it useless. The majority of these reports are based at least partly on the patients' statements. The inevitable conclusion is that patients' statements and estimations of treatment effect based upon them have no scientific value whatever.

He emphasized rest, posture, daily movements of the affected joints common nutrition, prevention and correction of deformities, physiotherapy occupational therapy, psychotherapy and rehabilitation as important parts of the treatment. Gold is generally thought to result in significant improvement. The place of Cortisone and ACTH is not settled.

Dr. Tucker, in discussing the orthopedic methods, advised that significant deformity is preventable. The prime objective of orthopedic treatment is the retention of the joints in the position of optimum function and the maintenance of strong and mobile joints.

If the onset of the disease is acute and sufficiently severe, the patient is usually quite willing to accept a full routine of treatment to get relief. With the more common type with an insidious onset, it is more difficult to convince the patient that he must follow a programme that will often seem drastic or out of proportion to the amount of discomfort he is suffering. It is the doctor's duty to give a full and careful explanation of the possible course of the disease and the methods which can prevent much crippling.

Providing the diagnosis is beyond question the first thing the patient must understand is that rheumatoid arthritis is a progressive crippling disease and if it goes on unchecked for many years, as it does in most cases, it can leave him a helpless cripple or at least seriously handicapped. The patient who understands the insidious nature of the disease will more readily accept a broad programme that will protect him from a state of great disability.

After showing the worst aspect of the picture to the patient, one can encourage him by explaining that there are ways of minimizing deformity and retaining a large measure of joint function. Manipulation has a useful place in the treatment of this condition but must be used with extreme

caution. Arthromy, arthroplasty, corrective, and arthrodesis are useful procedures under certain circumstances.

Miss Danard emphasized the early application of physiotherapy and noted that the physiotherapist can be of definite help in the relief of pain, improvement of weak atrophied muscles and joint motion. Heat and exercise can help retrieve lost function but if the physiotherapist is allowed to help in the prevention of some of the manifestations of arthritis, she and the patient will be spared long weeks of the disheartening task of trying to regain something that should never have been lost.

The comments from the floor, both critical and appreciative, indicated that the relatively small audience was deeply interested in the subject.



Deer Lodge Hospital

The Meeting of the Society was held at this Institution, Jan. 25th, and was a stupendous success. Vaisrub's Vagaries alone were worth the price of admission (i.e. driving to the hospital). The following (for those who did not attend) is a list of the demonstrations which were thoroughly appreciated by those who ventured out.

Cavity formation in Lung Infarcts, Dr. L. R. Coke; Handicraft, Mrs. E. E. Dimock and Miss M. Hermon; Recreational facilities, Mr. J. Huff; Two methods of repair of lower lip (film), Dr. E. W. Pickard; Prosthetic appliance, Mr. H. N. C. Davies; Carcinoma of the oesophagus, Dr. J. T. McDougall; Operative cholangiograms, Dr. C. E. Corrigan; Electroencephalography, Dr. J. Matas and Mr. D. Campbell; Pulmonary complications following glucose aspiration, Dr. J. L. Becksted; Pension statistics, Dr. V. J. McKenty; Intra-Oral conduc-

tion anaesthesia. Treatment of facial (Maxillary) injuries, Dr. N. W. Snider and Dr. W. J. Arnold; Familial emphysema in three brothers, Dr. J. Buchanan; Geriatric statistics, 500 autopsies. Kochrome of Pathology. Recent Parasitology cases, Dr. T. H. Williams; Museum of Medical Metaphysics, Dr. S. Vaisrub; Some Interesting X-ray films of various arthritic conditions, Dr. S. D. Russell; Multiple Myeloma, Dr. P. Green and Dr. J. Dundas; Prolapse of gastric mucosa through the pylorus, Dr. P. K. Tisdale and Dr. D. J. H. Martin; Emboli following fractures, Dr. E. J. Thomas and Dr. C. D. Lees; Liposarcoma of lung, Dr. J. Downey and Dr. C. B. Schoemperlen; Ventriculograms demonstrating Brain Tumors. Myelograms showing Lumbar Disc protrusions. Surgical decompression of orbit for exophthalmos. Series of casts in the manufacture of a skull plate for defects, Drs. O. S. Waugh, H. F. Cameron and G. A. Wauchope; Common skin conditions, Dr. Ken Davidson; Rehabilitation of disabled veterans, Mr. N. V. Brock; Management of Paraplegia. Drs. D. Swartz, Stephanson and E. Jones; Malignancy of Larynx, Dr. K. J. Austmann and Dr. M. M. Pierce; Films of interest, X-ray department. The Story of the Smith Peterson nail. Demonstration of Kellgren Diagnostic machine, Dr. D. Wheeler and Dr. S. Windle; Color Photography, Mr. Roy Moore; Physical Medicine, Dr. J. D. Pincock.

All exhibits were carefully prepared and merited close attention. Although it is difficult to select particular exhibits for comment the scope of the work being carried on in the "Management of Paraplegia," "Rehabilitation of Disabled Veterans" and "Physical Medicine" cannot be overlooked and should be mentioned. Great credit is due Dr. Dunlop, the committee in charge and those associated with the Demonstrations for the most enjoyable and instructive evening.

**By-Law on
Specialist Register
See Page 123**

**Medical Library Evening Hours
8 p.m. to 10 p.m.
Will Be Continued
January 4th to March 31st, 1952**

Post Graduate Medical Course

Arrangements are being made to conduct a Refresher Course similar to those held in previous years. The tentative date is during the week beginning April 14th, 1952.

Four guest speakers will be on the programme, including Dr. Chester Jones, noted internist from Harvard, and Dr. A. W. Farmer, Plastic and Traumatic Surgeon, Toronto.

Clinical sessions including round-table conferences will be held in the mornings at the Winnipeg General, St. Boniface, Deer Lodge and Children's Hospitals. Luncheon and dinner meetings will also be held during the week.

Only a limited number of candidates can be accepted for this course and so early registration is essential.

Applications will be accepted in the order in which they are received.

L. A. SIGURDSON, M.D., Chairman,
Publicity Committee.

Winnipeg General Hospital Large Tumor of Vulva

Dr. Brian Best

In 1942 the patient, then 35 years old, noticed a lemon sized growth on her vulva. During the next three years it grew until it reached the size of a football. It did not, however, interfere with normal delivery of a healthy child.

In 1951 examination revealed that the growth sprang from the right labium majorum and hung down to the knees. (Reporter's note: a photograph of the parts resembled the classical pictures of elephantiasis of the scrotum).

Physical examination revealed bowel in the upper part of the tumor and this was confirmed by x-rays. The presence of an inguinal hernia was confirmed later at operation. The mass was moderately firm, was dull on percussion except in its upper part, and did not transilluminate. It hung between her legs like a football.

At operation the tumor was found to arise from the round ligament. It was removed and the inguinal hernia was repaired. The growth weighed 2,600 grams (roughly 5 pounds) and, pathologically, was a fibromyoma of the round ligament.

Dr. Best said that there were 179 reported cases of such tumors varying in size from that of a kerne¹

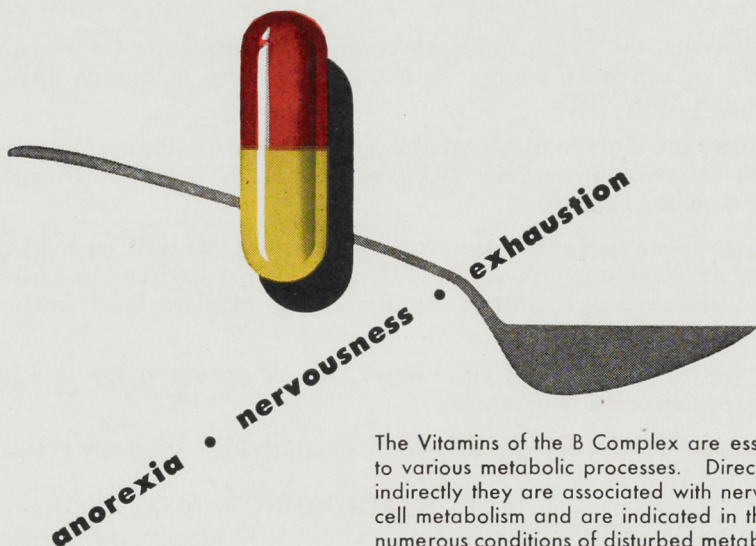
to one which weighed 31 pounds. These tumors occur three times more often on the right side, are extra abdominal three times out of four, and, in 8 per cent of cases, undergo sarcomatous degeneration. The rarity of the condition is shown by the fact that it was found only 6 times in 23,000 gynecological admissions to Johns Hopkins Hospital.

M. Lehman

REMEMBER Winnipeg Medical Society BENEVOLENT FUND

Subscriptions may be sent to
604 Medical Arts Building

By-Law on
Specialist Register
See Page 123



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Mild sedation is assured with Butabarbital.

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Sodium Butabarbital	1/2 gr.
Thiamine Hydrochloride	1.0 mg.
Riboflavin	2.0 mg.
Niacinamide	10 mg.
Pyridoxine Hydrochloride25 mg.
Calcium d-Pantothenate	1.25 mg.
Vitamin B ₁₂	1.25 mu.

capsule

Each teaspoonful contains:

Sodium Butabarbital	1/2 gr.
Thiamine Hydrochloride	1.0 mg.
Riboflavin	2.0 mg.
Niacinamide	10 mg.
Pyridoxine Hydrochloride25 mg.
d-Panthenol	1.25 mg.
Vitamin B ₁₂	1.25 mu.

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ETHICAL PHARMACEUTICALS

College of Physicians and Surgeons of Manitoba

Council Meeting

A Special Meeting of the Council of the College of Physicians and Surgeons of Manitoba was held Wednesday, May 23rd, 1951, at 7 o'clock p.m., in the Medical College, Winnipeg.

The President, Dr. I. Pearlman, called the meeting to order.

The business before the meeting was as follows:

1. Roll Call

The following members were present:

Doctors I. Pearlman, President; F. K. Purdie, Vice-President; T. H. Williams, Treasurer; B. D. Best, W. J. Boyd, C. E. Corrigan, C. S. Crawford, H. Guyot, Ed. Johnson, A. L. Paine, J. S. Poole, C. B. Stewart, C. H. A. Walton, C. W. Wiebe and M. T. Macfarland, Registrar.

2. Reading of Minutes and Their Approval

Dr. Pearlman stated that the minutes of the October Council Meeting had been circulated to the members of Council, and also published in the Manitoba Medical Review.

Motion: "THAT the minutes of the October Council Meeting be taken as read." Carried.

3. Reports of Officers and Their Consideration Treasurer's Report

Your Treasurer begs to report as follows:

In the Current Bank Account there was on hand at beginning of the current year Five Thousand, Five Hundred and Sixty-nine Dollars and Thirty-five cents (\$5,569.35). All bills and commitments have been paid and there is today on hand two Thousand Nine Hundred and Ninety-seven Dollars and Ninety Cents (\$2,997.90). This decrease in cash on hand in this non-interest bearing account is due to the purchase last month of Four Thousand Dollars (\$4,000.00) Dominion of Canada fully registered Three per cent (3%) bonds, 1966. This purchase was authorized by last Council meeting at the discretion of the Finance Committee who agreed to the purchase. Current income for the period since Council met has been approximately One Thousand Five Hundred Dollars (\$1,500.00) greater than current expenditure but for the coming six months will decline a little probably.

The Investment Trust Account has cash on hand of One Thousand Three Hundred and Twenty Dollars and Twenty Cents (\$1,320.20) and there are now a total of Sixty Thousand Dollars (\$60,000.00) in Three per cent (3%) fully registered Dominion of Canada bonds in the safety vault at the bank. This includes Four Thousand Dollars (\$4,000.00) in bonds recently bought from the current account. Payment of Seven Hundred and Fifty Dollars (\$750.00) to the Medical Library for the current year has been made.

The Gordon Bell Memorial Trust account has a cash bank balance on hand of Four Hundred and Seventy-one Dollars and Eight Cents (\$471.08). As authorized by last Council meeting a payment of One Thousand Dollars (\$1,000.00) plus bank transmission charge One Dollar and Fifty-six Cents (\$1.56) was made from this account to Dr. Ashley Thomson on post-graduate studies in England. One Five Hundred Dollar (\$500.00) bond in this account was called in and a replacement made by a Five Hundred Dollar (\$500.00) fully registered Dominion of Canada Three per cent (3%) bond, 1966. The total of bonds in this account at present amounts to Twenty-five Thousand Five Hundred Dollars (\$25,500.00).

From this account a grant has been approved by the Gordon Bell Memorial Fund Committee to Dr. Colin Ferguson of One Hundred and Fifty Dollars (\$150.00) per month for one year commencing July 1, 1952.

Respectfully submitted,

T. H. Williams, M.D., C.M.,

Treasurer.

Motion: "THAT the Treasurer's report be adopted." Carried.

4. Reports of Standing Committees and Their Consideration

A. Executive Committee

The Chariman advised there had been three meetings of the Executive Committee held since the October Council meeting (January 31, 1951; March 9, 1951; April 30, 1951), and copies of all minutes had been distributed to each member of Council.

Motion: "THAT the report of the Executive Committee be accepted." Carried.

Business Arising From Minutes of Executive Committee Meetings

(a) Disciplinary By-law

The Registrar reported that the Disciplinary By-law had been studied by the Executive Committee at the meeting of January 31st, and the following resolution was adopted:

"THAT the Executive Committee approves of the Discipline By-law, and recommends that the maximum fine under paragraph 4, number 3 be Fifty Dollars (\$50.00), and the maximum fine under paragraph 4, number 5 be One Hundred Dollars (\$100.00)."

The Registrar pointed out that the erasure clause is dealt with in the Medical Act itself, and this was a special by-law intended to deal with offences that were not considered serious enough to warrant erasure, but the final item of the by-law is erasure from membership in the College of

Physicians and Surgeons. An outline of conditions warranting erasure is also included.

Motion: "THAT the Disciplinary By-law be adopted, with amendment of the Executive Committee, January 31, 1951, included." Carried.

(b) Temporary Licence—Graduate Internes

The Registrar reported he had written in December to the Associated Hospitals of Manitoba, advising that the October, 1950, meeting of Council had agreed that all hospitals employing graduate internes should be circularized, emphasizing the existence of the Certificate of Licence at a reduced fee. As a result of this letter the Board of Directors set up a sub-committee to investigate the licensing of graduate internes in the Province. The sub-committee, consisting of five hospital administrators, prepared a brief which was presented to the Board of Directors, and the following resolution was approved:

"BE IT RESOLVED: (a) That the Board of Directors of the Association Hospitals of Manitoba agree with the principle that graduate internes should be licensed.

(b) That hospitals employing graduate internes are urged to co-operate with the College of Physicians and Surgeons in every respect.

(c) That the monthly stipend paid to any resident staff will have no bearing on the granting of a license.

(d) That this Association goes on record as strongly in support of the granting of licenses without charge, to graduate internes in recognized hospitals, provided, however, that licenses are granted to such internes who meet the qualifications which would allow them to be licensed in the Province of Manitoba."

During discussion it was pointed out that the fee for temporary licence for graduate internes was very small—Five Dollars (\$5.00) for internes earning up to One Hundred Dollars a month, Ten Dollars (\$10.00) for internes earning over One Hundred Dollars a month, plus the annual fee of Five Dollars (\$5.00) in each case.

During the past few years there have been medico-legal problems involving graduate internes, and temporary licence would give them some protection. In England all internes must be registered with the General Medical Council of Great Britain.

Motion: "THAT the communication from the Associated Hospitals of Manitoba be acknowledged, and they be advised that this College cannot favourably consider the suggestion that the Certificate of Licence be issued to graduate internes without fee." Carried.

(c) Irregulars

The Registrar explained that he had asked the solicitor to draft a suitable letter to the Manitoba Chiropractors Association, concerning verbal communications with the Secretary of the Association, outlining the policy of the Council.

He presented a letter prepared by the solicitor advising that one of their members was convening the Basic Sciences Act and the Medical Council since he was using the descriptive title "doctor" and deceiving the public by misleading advertisement. The letter further states that the College would like the assurance of the co-operation of the Chiropractors Association should it be decided to lay charges, but that they were not attacking Chiropractors as such, since they have a recognized place in their own field and the medical profession is not in competition with them, and that their action would be withheld until the matter was discussed further with their members or the Registrar.

Motion: "THAT a letter, based on the solicitor's suggestions, be sent to the Manitoba Chiropractors Association." Carried.

(d) Appointment of Auditors

Motion: "THAT the firm of Price, Waterhouse and Company be appointed auditors for the year 1950-1951." Carried.

(e) Appointment of Representative to University Senate

Dr. Walton advised he had raised this question at the last meeting of the Executive Committee on April 30th. He said that the University starts on the first of September, and since the College year starts on the first of October, and Council does not appoint a representative to the University Senate until the middle of October, there is no College representative on the Senate for the first two meetings.

Motion: "THAT Dr. C. H. A. Walton be appointed our representative to the University Senate, to take effect at the beginning of the University year." Carried.

(f) Date of Annual Council Meeting

It was suggested that the date of the annual Council meeting be changed, to be held concurrently with the meeting of the M.M.A., so that rural members would not have to come to Winnipeg twice. The M.M.A. Convention is held on October 9-12, and the date of the Council meeting, fixed by by-law, is October 17th.

Motion: "THAT the date of the Annual Meeting of Council be set by the President at his discretion." Carried.

It was suggested that the members of Council be informed as early as possible of the date of the meeting.

Notice of Motion by Dr. Ed. Johnson: "That Section 1 (0) of the By-laws be changed, giving Council power to set the date of the annual Council meetings."

(g) Re University of Manitoba Granting M.D. Degree End of Fourth Year

Dr. J. M. Lederman, Secretary, Faculty of Medicine, University of Manitoba, appeared

the Council. He said that recently the Executive of the Medical College had recommended in principle that the interne year be dropped as an undergraduate year in the Faculty of Medicine. It was felt that the C.P. & S. should be consulted before dropping the interne year and granting the M.D. at the end of the fourth year. The Executive felt that the decision would depend on whether some method might be worked out whereby it would be necessary for the person to undergo a period of one year's internship satisfactory to the Faculty or the College or the two bodies in conjunction, also whether Manitoba's reciprocal agreements with other bodies would be affected. Dr. Lederman circulated copies of the report of the Special Committee appointed to study the question.

Dr. Corrigan, who is a member of the Special Committee of the Faculty Council Executive appointed to consider the granting of the M.D. degree at the end of the fourth year, stated this matter was of some urgency in view of the international situation. Because their internship is undergraduate, Manitoba graduates lose one year's seniority, in comparison with graduates from other schools when joining the Forces, applying for internships in the United States and in preparing for the higher examinations. He said that if Council approved this suggestion, it would be up to the Council to insure that any graduate from the University of Manitoba would not be granted an Enabling Certificate until he had served a year's internship in an approved hospital, and it would be up to Council to prepare a list of approved hospitals. The University of Toronto gives the degree the end of the fourth year, and in their experience, something like 2% do not serve an internship.

Dr. Walton suggested that the Medical Act, Section 31 (b) be amended by adding the clause "and upon satisfactory completion of one year's internship in an approved hospital." He suggested the solicitor might be asked to go through the Act with reference to suitable amendments to control internship. The amendment would go before the Legislature next winter.

Dr. Lederman advised that the first class which would be able to graduate without internship would be the present class going into fourth year, and that in 1952 there would be a double graduating class. He also said there was a survey in progress by the University of Manitoba, of the hospitals as to their suitability for internships.

Motion: "THAT the Council of the College of Physicians and Surgeons of Manitoba agrees in principle with the proposals put forth by the Faculty Council Executive of the University of Manitoba that the obligatory undergraduate year be discontinued, and that appropriate action be undertaken." Carried.

Notice of Motion by Dr. C. E. Corrigan: "THAT reconsideration be given to the motion concerning internships passed at a meeting of the Education Committee, October 18, 1948, and approved by Council, October 20, 1948."

(h) Suggestions for Discussion at Meeting of Registrars in Montreal in June

The following subjects were suggested for discussion by the Registrars:

1. Uniform licence fee.
2. Fee for Enabling Certificates for foreign graduates-inquire and advise.
3. Question of common procedure with regard to employees of Dominion and Provincial Governments, and Armed Forces.
4. Number of foreign graduates coming to Canada with no prospect of employment although the Department of Immigration advises they will have no trouble. There are ten licensing bodies and doctors may contact all ten bodies. The possibility of setting up a clearing house for those from other countries.
5. One licence in Canada.

(i) Increase in Fee for Enabling Certificates

Dr. Walton said the Registration Committee spends much of its time dealing with applications from various types of foreign medical graduates from Asia, Europe and U.S.A., who wish to register in Manitoba to practise elsewhere. These individuals have been charged the fee of Five Dollars (\$5.00) for their Enabling Certificate if it was granted. He suggested that owing to the great amount of extra work involved in studying the qualifications of these applicants, a larger fee should be charged. One way would be to simply raise the fee from \$5.00 to a figure set by Council, or to raise the fee and apply a portion on account of the registration fee. He thought the latter method would be more satisfactory, and suggested the fee of Twenty-five Dollars (\$25.00) be charged for the Enabling Certificate, Twenty Dollars (\$20.00) of which would be credited in the event of registration.

Dr. Corrigan said he agreed with Dr. Walton's suggestion, but thought the Council would be open to criticism if any discrimination were made between Manitoba graduates and others. He suggested that most Manitoba graduates eventually register here, and would not be out of pocket.

The Registrar said that while approximately 80% of the graduating class receive Enabling Certificates from this College, only a small percentage become registered immediately, although others register after a year or more post-graduate work.

Notice of Motion by Dr. C. H. A. Walton: "THAT for graduates other than those of the University of Manitoba, the fee for an Enabling Certificate be Twenty-five Dollars (\$25.00), and upon subsequent registration Twenty Dollars (\$20.00) be credited to the registration fee."

B. Registration Committee

1. The Committee met on five occasions since its appointment in October, 1950 (November 6, December 22, 1950; March 14, April 24, May 17, 1951).

2. There have been no major difficulties during this time. Manitoba continues to be used as a registration device by doctors who have no intention of practising here. These included Chinese applicants and American applicants who are desirous of British registration. In addition there are graduates of Canadian schools who are unable to get enabling certificates in other provinces because of lack of citizenship. Citizenship is not required in Manitoba for registration. The problem of refugee doctors from Europe continues to be difficult. In general, internships seems to offer the best solution to the language difficulty and to the difficulty in evaluating qualifications. Those who have taken their internship seem to get along fairly well in their Dominion Council examinations. There are some refugee doctors who have had difficulty acquiring Basic Science qualification and in this connection the Basic Science Act offers partial screening.

3. The cost of dealing with applications for enabling certificates from candidates outside of Manitoba is very heavy and the present fee of \$5.00 is entirely inadequate. You will be asked to consider a change of this fee today.

All of which is respectfully submitted,

C. H. A. Walton, M.D.,

Chairman.

Motion: "THAT the report of the Registration Committee be adopted." Carried.

C. Education Committee

No report.

D. Finance Committee

Dr. Williams advised there was no report of the Finance Committee, it was covered in the Treasurer's Report.

E. Legislation Committee

Dr. Poole advised a meeting of the Legislation Committee had been held May 2nd, and that mimeographed copies of the minutes had been circulated to the members of Council.

Specialist Register

Motion: "THAT the recommendation concerning a Specialist Register be accepted, omitting the phrase "and two from the Manitoba Medical Service" from item 2." Carried.

Dr. Poole said it would be necessary to appoint a committee to prepare a list of specialists.

Motion: "THAT the Executive Committee appoint two members of the College of Physicians and Surgeons of Manitoba to a committee to prepare a list of specialists in Manitoba, and that the Registrar communicate with the Faculty of Medicine, University of Manitoba, and the Mani-

toba Medical Association, to appoint two members each to the committee." Carried.

Electoral Districts

Dr. Poole outlined the various medical electoral districts on a map. He explained that the idea of electing half the Council every two years was to insure that there would not be a brand new Council each election year, with only half a dozen members who were conversant with the business being transacted.

Notice of Motion by Dr. J. S. Poole: "THAT the suggested changes in the medical electoral districts be adopted."

F. Library Committee

No report.

G. Discipline Committee

The name _____ was erased from the Register of the College of Physicians and Surgeons of Saskatchewan. The reason—unprofessional conduct. Your Committee has reviewed the evidence submitted by the Saskatchewan Council. _____ Dr. _____ may practise in any part of Canada provided his name is retained on the Register of any province of the Dominion, this Council shall follow the action of the Council of the C.P.S. of Saskatchewan, and erase Dr. _____ from our Register.

Respectfully submitted,

C. W. Wiebe, M.D.

Chairman

Motion: "THAT the name of _____ be erased from the Register of the College of Physicians and Surgeons of Manitoba." Carried.

H. Taxing Committee

No report.

5. Reports of Special Committees and their Consideration**A. Representatives to the Manitoba Medical Association Executive**

Dr. Ed. Johnson advised he had attended all of the meetings of the Manitoba Medical Association Executive, and various questions had been referred to the Liaison Committee, which will be discussed later in the meeting.

B. Trustees of the Gordon Bell Memorial

The Registrar presented communication from the Secretary of the Gordon Bell Memorial Trustees, recommending that Colin Campbell Ferguson, M.D., University of Manitoba, 1945, be granted a Fellowship amounting to One Hundred and Fifty Dollars (\$150.00) a month for the year commencing July 1, 1952, to enable him to pursue studies and research in the field of cardiovascular surgery in Boston.

Motion: "THAT Dr. Colin Campbell Ferguson be granted One Hundred and Fifty Dollars (\$150.00) a month for the year commencing July 1, 1952, from the Gordon Bell Memorial Accounts, as recommended by the Trustees." Carried.

C. Representatives to the Committee of Fifteen

The Registrar advised there had been a meeting of the Committee of Fifteen which had been considered at the meeting of the Executive Committee on March 9th, 1951.

Motion: "THAT the action of the Executive Committee concerning the Committee of Fifteen be accepted." Carried.

D. Representative to the Committee on Admissions

No meeting.

E. Representatives to the Medical Council of Canada

No meeting.

F. Representative to University Senate

1. Your representative has attended most of the meetings of the Senate of the University of Manitoba since the last report. There have been no important matters concerning this College arising in the Senate. The only question on which I was asked a specific opinion was that dealing with compulsory physical education for university students. I am not sure that I personally agree with the compulsory features, but I did not feel the matter was of sufficient importance to engage the attention of this College seriously.

2. As a member of the Senate I served on two important committees, namely the "Basic Sciences Committee" and the "Committee on Nursing Education." The Basic Sciences Committee is now operating smoothly and efficiently. The Committee has finally decided that all chiropractors requesting a certificate of qualification in Basic Sciences must submit to the university examinations in these subjects. The first candidate to write under this regulation failed completely to qualify. Another group is writing in June.

3. The Committee on Nursing Education has carried out its routine business. During the current year there were two candidates in the course of Nursing Education and Supervision in addition to the usual number studying Public Health. The question of the curriculum of the School of Nursing Education is under study but no specific changes are anticipated at the moment.

4. The College appoints its representative to the Senate at the Annual Meeting of Council in October. The University year starts on the first of September. In consequence, there is no representative of this Council on the Senate for the first two months of each academic year. This matter has been drawn to the attention of the Executive and will be considered on today's agenda.

All of which is respectfully submitted,

C. H. A. Walton, M.D.

Motion: "THAT the report of the representative to the University Senate be adopted." Carried.

G. Representative to the Cancer Institute

The Registrar advised the Annual Meeting of the Cancer Institute would be held June 1st, 1951.

H. Representatives to the Liaison Committee**M.M.A.-C.P. & S.**

Motion: "THAT the College of Physicians and Surgeons increase the salary paid to Dr. M. T. Macfarland by Eight Hundred Dollars (\$800.00) per annum as from April 1st, 1951. Further that the salary paid be reviewed at the Annual Meeting of 1951, and from time to time as may be indicated." Carried.

Motion: "THAT Miss Jean Allison be appointed Assistant to the Registrar of the College of Physicians and Surgeons of Manitoba as from Sept. 1st, 1951, at a salary of One Hundred and Seventy-five Dollars (\$175.00) per month, with increase from time to time to Two Hundred Dollars (\$200.00) per month." Carried.

Motion: "THAT the equivalent of one month's salary, One Hundred and Seventy-five Dollars (\$175.00) be advanced to Miss Jean Allison as an expense account to interview Registrars' Assistants in Eastern Canada and the General Medical Council in Great Britain." Carried.

Motion: "THAT we approve of the payment of a fixed sum for office and equipment use to be paid to the Manitoba Medical Association, and that this sum be fixed by the Executive after receiving a report of the Liaison Committee on the matter." Carried.

I. Representative to the Canadian Arthritis and Rheumatism Society

The Registrar reported that the Canadian Arthritis and Rheumatism Society would be holding a drive for funds, and that all Winnipeg members of the medical profession would receive notification.

6. Election of Officers and Standing Committees

Not applicable at this meeting.

7. Reading of Communications, Petitions, etc. to the Council**A. Communication From Department of Trade and Commerce Re Colombo Plan**

The Registrar presented a letter from the Department of Trade and Commerce advising that the Colombo Plan is a Commonwealth Scheme whereby the more fortunate countries can aid undeveloped countries by sending technicians to those countries and by accepting trainees in this country. The present recipient countries are Ceylon, India and Pakistan, and the contributing countries are the United Kingdom, Canada, Australia and New Zealand. Applications for nine specialists required by these countries were enclosed.

For information—no action was taken.

B. Complaint Against Dr.

The Registrar presented a letter from a lawyer, enclosing account from Dr. against a

patient, which was considered excessive.

Motion: "THAT the complaint concerning the fee charged by Dr. _____ be referred to the Taxing Committee." Carried.

C. Communication From Editor, Manitoba Medical Review

The Registrar presented the communication from the Editor of the Manitoba Medical Review, in which he advises he has an article by a distinguished authority, with a number of cuts which would cost about Twenty-five Dollars (\$25.00) to reproduce, and requesting that the College undertake the cost of supplying the cuts.

Motion: "THAT the Editor of the Manitoba Medical Review be advised that this College cannot concur with his request to pay for cuts for an article in the Review." Carried.

D. Request From Dr. D. W. McCord, Secretary Medical Arts Building

The Registrar reported that Dr. McCord had inquired about the possibility of the Winnipeg Dental Society, the Manitoba Dental Association, the Winnipeg Medical Society, the Manitoba Medical Association, and the College of Physicians and Surgeons, each supplying one or two good magazines for use in the Medical Arts Club Room, since the latter is used freely for meetings.

Motion: "THAT the College of Physicians and Surgeons purchase a subscription to a magazine for use in the Medical Arts Club Room, up to the sum of Fifteen Dollars (\$15.00)." Carried.

8. Inquiries

A. Inquiry From Canadian Medical Association Re Internships for Foreign Graduates

The Registrar presented a letter from the Assistant Secretary, Canadian Medical Association, advising that he had communicated with all hospitals on the Approved and Commended Lists of the Association, inquiring whether they would have internships available for graduates of foreign medical schools. He suggested that before distributing the information received from the various hospitals, the Registrars should examine it, and advise if there was any reason why it should not be distributed, or if it should be modified. He inquired whether this College would concur in an application being made to a hospital in this province by a foreign doctor whose credentials have been examined by the licensing authority of another province, and advice given to return following a rotating internship. He advised further that such a list of available hospital openings would be revised about every six months, lists being sent to each Registrar to be handed out directly to foreign applicants.

The Council were in accordance with the suggestions of the Canadian Medical Association.

B. Inquiry From Canadian Association of Medical Students and Internes

The Registrar presented a letter from the Association Editor of the Journal of the Canadian Association of Medical Students and Internes advising that in their October issue, they are running a survey of the field of medicine in Canada from the point of view of the medical student of the general practitioner, as well as data on requirements to practise in each of the provinces of Canada, requirements for specialization, etc.

The council agreed that the requested information be forwarded to the Journal of the Canadian Association of Medical Students and Internes.

9. Notices of Motion

(a) **Notice of Motion** by Dr. Ed. John: "THAT Section 1 (0) of the by-laws be changed giving the Council power to set the date of annual Council meetings."

(b) **Notice of Motion** by Dr. C. E. Corrie: "THAT reconsideration be given to the motion concerning internships passed at a meeting of the Education Committee, October 18, 1948, and approved by Council, October 20, 1948."

(c) **Notice of Motion** by Dr. C. H. A. Walton: "THAT for graduates other than those of the University of Manitoba, the fee for an Enabling Certificate be Twenty-five Dollars (\$25.00), and of subsequent registration Twenty Dollars (\$20.00) be credited to the registration fee."

(d) **Notice of Motion** by Dr. J. S. Poole: "THAT the suggested changes in the medical electoral districts be adopted."

10. Motions of Which Notice Has Been Given at a Previous Meeting

(a) The following Notice of Motion was heard by Dr. C. H. A. Walton at the October meeting of the Council:

"THAT members of His Majesty's Permanent Forces stationed in Manitoba, and full time employees in the public service of Canada stationed in Manitoba, be accepted for temporary licence with the College of Physicians and Surgeons of Manitoba, provided they are registered and in good standing with one Province of Canada, have payment of the Annual Fee."

Motion: "THAT the By-law drawn up by the solicitor, and presented to the Executive Committee, April 30th, 1951, be adopted." Carried.

Motion: "THAT no registration fee be required if the applicant is registered and in good standing with a Province of Canada, but if he is not registered, that he pay the licence fee of Forty Dollars (\$40.00), plus the annual fee." Carried.

(b) The following Notice of Motion was heard by Dr. C. H. A. Walton at the October meeting of the Council:

"THAT the Council may authorize the issuance of Certificate of Licence to qualified physicians who are undertaking a Locum Tenens for an

physician. The Licence shall be valid for a period of three months and shall not be renewable. The fee for such Licence shall be Ten (\$10.00), plus the Annual Fee."

Motion: "THAT the by-law drawn up by the solicitor, and presented to the Executive Committee, April 30th, 1951, be adopted, with the suggested change to twelve months in paragraph two." Carried.

Motion: "THAT if during the life of the Locum Tenens Licence, an application is made for full registration, that the initial Ten Dollars (\$10.00) be applied on the registration fee." Carried.

11. Unfinished Business

None.

12. Miscellaneous and New Business

A. Amount to be Paid to Council Members for Attendance at This Meeting

Motion: "THAT the amount paid to members of Council for attendance at this meeting be the same as for the October, 1950, Meeting." Carried.

B. Payment of Janitor

Motion: "THAT the amount paid to the janitor for his services, and costs of refreshments, be Ten Dollars (\$10.00)." Carried.

Adjournment.

Manitoba Medical Service

48th Annual Convention of Union of Manitoba Municipalities

Address to Delegates on 28th November, 1951,
by Dr. P. H. McNulty, Chairman of Manitoba
Medical Service and Chairman Trans-
Canada Medical Services

Mr. Chairman, Gentlemen:

It is an honour to be with you on the occasion of your 48th Annual Convention, and I bring to you the cordial greetings of the Board of Trustees of Manitoba Medical Service, with our best wishes for success in your efforts to do still more for the people whom you represent and guide.

It is a special privilege for me to speak, for a few moments of your time, on the subject of Manitoba Medical Service, which is very close to the hearts of many of us. It would be impossible, in the time so kindly allotted to me, to take you over the subject, so I shall give attention to one or two aspects of it and would be glad to have further enquiries on it. We hope to have new folders available by tomorrow to show our proposals for 1952. Now for those, and I trust they are few in number, who are not too familiar with the philosophy of the M.M.S., I will start off by saying that—

The M.M.S. is the medium through which two parties are brought into contact for provision of medical care. There is the subscriber on the one hand with his monthly premium, which he pays to M.M.S. through a local group leader or directly to the M.M.S. office. There is the doctor on the other hand, who provides the skills and care for the subscriber and his family. The fee tariff of the doctor is one compiled by Manitoba Medical Association. This arrangement takes the "dollar" out of the relationship between patient and doctor, and this can be an excellent device especially where the costs of care are heavy, unpredictable and likely to continue for some time. In short, the M.M.S. dips into the common pool of

premiums and pays the bill directly to the doctor. Is this a good idea? It is, most certainly! Apart from the great number of general practitioners and specialists in Winnipeg, we have 145 medical members practising in Manitoba at large, enthusiastically behind the Plan. Let me read the names of the localities of the doctors:

Altona, Arborg, Ashern, Baldur, Beausejour, Belmont, Benito, Binscarth, Boissevain, Birtle, Bissett, Brandon, Carberry, Carman, Cartwright, Crystal City, Dauphin, Deloraine, Dominion City, Elm Creek, Emerson, Ethelbert, Flin Flon, Hamiota, Hartney, Kenton, Killarney, Lundar, Manitou, MacGregor, McCreary, Melita, Minnedosa, Morden, Morris, Neepawa, Newdale, Notre Dame de Lourdes, Oakville, Pine Falls, Pilot Mound, Portage la Prairie, Rivers, Reston, Roblin, Roland, Rossburn, Russell, Selkirk, Sherridon, Souris, St. Jean Baptiste, St. Pierre, Ste. Anne des Chenes, Ste. Rose du Lac, Steinbach, Stonewall, Swan Lake, Swan River, Teulon, The Pas, Transcona, Treherne, Virden, Whitemouth, Winkler, Winnipegosis.

It is also the only plan in Manitoba sponsored and endorsed by the Manitoba Medical Association, which is the official voice of Medicine in this province. What is the public attitude? At the moment, we have 118,227 persons covered, an increase of 35,000 since I met with you here a year ago. Of these persons, 1 in 6 receives care every month. It used to be 1 in 10, so that people do need it more and use it more. They cannot, however, pay the premiums which should be charged for the quantity of care provided, so that a deficit appears every month. This deficit is absorbed by the doctors rendering the service. There is an important principle behind this — the pro-rating principle and one which will give stability and permanence to this plan when all other plans shall have collapsed under the pressure of an unwanted but nevertheless potential depression. It is a good test to apply to insurance and other plans as money gets tighter.

Needless to say, the patient must have free choice of doctor, and he can seek him out anywhere in the province. The benefits are as wide as the prairie. We do not limit X-ray costs as do other plans. There is no age limit in our group plans. From 1st January next we are taking care of the costs of anaesthesia in the hospital, a liability which has so far been carried by the Blue Cross plan. We have special benefits for continuous care of the new born babe right through till his second year has passed, apart from the general benefits to which he is entitled.

We will accept applicants as groups or as individuals. Now we have gone farther in anticipating the needs of our people and will provide a Serviceman's Family Plan from 1st January for this very deserving category of dependents of men in the Armed Services.

Do you see what our aim is? We are studying to anticipate and meet the needs of the people and trying to do what you try to do—to give as much as we can and raise the standards of service all along the line.

Mindful of the deficit every month, you can see how true is our claim that M.M.S. is a non-profit organization. Who are these people who shape the policy? In answer, they are public-spirited laymen and physicians; men like Hugh Macintyre of your organization, whom we are proud to have as a member of our governing body; men like the other six laymen on our Board—all representing particular and special points of view and providing a good cross section of the interests of our province. Notice too that there are no fees for our Directors. The medical representation is likewise a cross section of the profession. Here then, we have a very happy and experienced "brains trust" to give the M.M.S. its typical Manitoba slant—and that is how we would all want it—we have to take heed of the special needs, facilities, resources and methods of practice in this province and embody these in a plan suitable for our way of life.

The M.M.S. has grown rapidly and will expand in every direction, giving nothing but the best in the way of surgical, medical or maternity care. The best can be very expensive and burdensome but please remember this fact, and an important one it is, that the M.M.S. doctor cannot charge extras to the patient for services within the contract. Does that not give a sense of security to the family man working out a meagre budget?

We think it does, and this feature of M.M.S. is in which we take a justifiable pride.

Now, I may be asked, could you help M.M.S.? Certainly you could, and I am sure you would as custodians of the welfare of the public. Let me suggest ways in which you might help:

Well, you gentlemen could sponsor meetings to have M.M.S. explained in your localities by your staff; you could commend the plan to your people; you could organize a group and act as leader of it; you could give municipal endorsement to the movement. At a higher level, you could do more, but we shall have to leave it at that. I know the time that you allotted so kindly to me is already exhausted and you have items of importance to discuss. In leaving you, I would make a plea to each official here to give careful thought to the world-wide need and demand for medical care of the highest quality available. The people's needs must not be denied. It must be provided either by compulsory plans or voluntary plans. Compulsory plans are distasteful to our people. The voluntary principle is something we cherish. The ideal agency to embody these principles would be one consisting of the public on the one hand and the doctors on the other. That is, those receiving the service and those rendering it.

It is my submission to you gentlemen, that if we are in partnership, we can develop the M.M.S. to the utmost and provide for our people a plan which will be the pattern for all of Canada to adopt. I can tell you, as Chairman of the Trans-Canada Medical Services, that our plan is not without admirers and imitators.

While we cherish here the old-fashioned principles of freedom and self help, let us also remember to find ways and means for those unable to help themselves in paying their way.

In closing, I would leave with you this thought: that M.M.S. is a unique social experiment deserving the effort of every progressive warm-blooded thinker in this province, so that the highest quality of medical care can be brought into the home of our people by you and us, in partnership.

**By-Law on
Specialist Register
See Page 123**

College of Physicians and Surgeons of Manitoba

Specialist Register

The following by-law was approved at the Annual Meeting of Council on October 13th, 1951:

WHEREAS the College of Physicians and Surgeons of Manitoba deem it desirable that a Register of Specialists be established and maintained by the College.

AND WHEREAS The Medical Act provides for the recording of higher degrees or additional qualifications of persons whose names appear on the Manitoba Medical Register.

NOW THEREFORE BE IT ENACTED and it is hereby enacted as follows:

1. That the Council do establish and maintain a Register to be kept by the Registrar to be known as the Specialists Register in which shall be entered the names of all persons who have complied with the provisions hereof.

2. Any person whose name appears in the Manitoba Medical Register and who is either:

- (a) A Fellow of the Royal College of Physicians and Surgeons of Canada; or
- (b) A certificated specialist of the Royal College of Physicians and Surgeons of Canada;

shall be entitled to have his name entered in the Specialists Register.

3. Any person whose name appears in the Manitoba Medical Register may at any time before January 1st, 1954, make application to be registered as a specialist and upon approval of his application by the special committee, appointed as hereinafter provided, may have his name entered in the Specialists Register.

4. The special committee hereinbefore referred to shall consist of six members as follows:

- (i) Two representatives of the College of Physicians and Surgeons of Manitoba appointed by the Council and of whom one shall be the chairman of the committee;
- (ii) Two representatives of and appointed by the Faculty of Medicine of the University of Manitoba; and
- (iii) Two representatives of and appointed by the Manitoba Medical Association.

The members of the committee shall hold office until and including the 31st day of December, 1953, on which day the said committee shall cease to function. It shall be the duty of the committee to pass upon the qualifications of any applicant for registration in the Specialists Register to accept or reject the application.

5. On and after the 1st day of January, 1954, either a fellowship of the Royal College of Physicians and Surgeons of Canada or an enrollment therein as a certificated specialist shall be accepted standard for registration as a specialist, provided, however, in special circumstances a person whose name appears in the Manitoba Medical Register and who is not a Fellow or certificated specialist of the Royal College of Physicians and Surgeons of Canada may apply to have his name entered in the Specialists Register. The Council, after inquiry into the circumstances of the case, may in its sole discretion accept or reject such application and if accepted direct that upon payment of the prescribed fee the name of the applicant be entered in the Specialists Register.

Application form accompanied by supporting documents and the fee of Five Dollars (\$5.00) payable at par in Winnipeg, should be forwarded to Dr. M. T. Macfarland, Registrar, 604 Medical Arts Building, WINNIPEG, Manitoba.

codophen *E.B.S.*

SEDATIVE · ANALGESIC

for little patients

for adult patients

* CODOPHEN C.T. No. 260

Each tablet contains:

Acetylsalicylic Acid 3 gr.
Phenacetine 2 gr.
Caffeine Citrate $\frac{1}{4}$ gr.
Codeine Phosphate $\frac{1}{4}$ gr.

* CODOPHEN PAEDIATRIC C.T. No. 259

Each tablet contains:

Acetylsalicylic Acid $\frac{7}{8}$ gr.
Phenacetine $\frac{1}{2}$ gr.
Caffeine Citrate $\frac{1}{8}$ gr.
Codeine Phosphate $\frac{1}{8}$ gr.

* CODOPHEN STRONGER C.T. No. 260A

Each tablet contains:

Acetylsalicylic Acid 3 gr.
Phenacetine 2 gr.
Caffeine Citrate $\frac{1}{4}$ gr.
Codeine Phosphate $\frac{1}{2}$ gr.

* Narcotic Order Required. Codophen tablets are orange coloured but are otherwise unmarked.



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AN ALL CANADIAN COMPANY . . . SINCE 1879

Representative: Mr. S. M. Fairclough, 542 Ingersoll Street, Winnipeg

Department of Health and Public Welfare Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1951		1950		Total	
	Nov. 4 to Dec. 1, '51	Oct. 7 to Nov. 3, '51	Nov. 5 to Dec. 2, '50	Oct. 8 to Nov. 4, '50	Jan. 1 to Dec. 1, '51	Jan. 1 to Dec. 2, '50
Anterior Poliomyelitis	11	10	1	1	47	17
Chickenpox	196	112	234	170	1536	1510
Diphtheria	0	0	0	0	5	16
Diarrhoea and Enteritis, under 1 yr.	6	18	6	6	145	141
Diphtheria Carriers	0	0	0	0	1	3
Dysentery—Amoebic	0	0	0	0	0	2
Dysentery—Bacillary	1	1	0	3	25	128
Erysipelas	3	2	2	1	30	47
Encephalitis	0	2	0	0	4	2
Influenza	4	2	3	10	776	213
Measles	99	39	128	103	2938	1355
Measles—German	3	3	0	4	44	35
Meningococcal Meningitis	1	3	0	2	34	17
Mumps	124	69	144	79	1317	536
Ophthalmia Neonatorum	0	0	1	0	2	3
Pneumonia—Lobar	12	16	26	13	238	227
Rubeolar Fever	0	0	0	0	1	4
Scarlet Fever	110	105	66	64	1230	417
Septic Sore Throat	10	2	1	5	37	48
Smallpox	0	0	0	0	0	0
Tetanus	0	1	0	0	1	2
Trachoma	0	0	0	0	0	1
Tuberculosis	90	63	56	80	890	956
Typhoid Fever	0	1	0	1	3	4
Typhoid Paratyphoid	0	0	0	1	0	1
Typhoid Carriers	0	0	0	0	0	2
Undulant Fever	0	1	0	2	9	31
Whooping Cough	107	66	88	92	516	455
Gonorrhoea	109	90	94	128	1161	1218
Syphilis	11	8	21	11	145	215
Ulceremia	0	0	0	0	0	5

Four-Week Period November 4th to December 1st, 1951

*DEATHS FROM REPORTABLE DISEASES

For the Month of November, 1951

DISEASE (White Cases Only)	*779,000 Manitoba	*861,000 Saskatchewan	*3,825,000 †Ontario	*2,952,000 Minnesota
Anterior Poliomyelitis	11	5	60	40
Chickenpox	196	305	2105	---
Diarrhoea and Enteritis, under 1 yr.	6	---	---	---
Diphtheria	---	---	---	9
Diphtheria Carriers	---	---	---	---
Dysentery—Amoebic	---	---	---	1
Dysentery—Bacillary	1	---	5	10
Encephalitis Epidemica	---	2	1	1
Erysipelas	3	5	---	---
Influenza	4	1	9	1
Rubeola, Infectious	---	2	12	---
Measles	99	31	428	65
German Measles	3	42	80	---
Trachoma	---	---	1	---
Meningitis Meningococcal	1	2	7	5
Mumps	124	99	1149	---
Ophthalm. Neonat.	---	---	---	---
Pneumonia, Lobar	12	---	---	---
Rubeolar Fever	---	---	---	---
Scarlet Fever	110	174	146	56
Septic Sore Throat	10	37	---	18
Smallpox	---	---	---	---
Tetanus	---	---	---	---
Trachoma	---	---	---	---
Ulceremia	---	---	---	---
Tuberculosis	90	61	112	162
Typhoid Fever	---	1	2	---
Typh. Para-Typhoid	---	---	---	1
Typhoid Carrier	---	---	---	---
Undulant Fever	---	---	1	---
Whooping Cough	107	38	240	25
Gonorrhoea	109	---	167	---
Syphilis	11	---	34	---

Urban—Cancer, 56; Influenza, 1; Pneumonia, Lobar (490), 2; Pneumonia (other forms) (491-493), 6; Pneumonia of Newborn, 2; Poliomyelitis, 1; Tuberculosis, 5; Dysentery, 1; Meningococcal Infections, 1; Chickenpox, 1; Benign Neoplasms, 1; Diarrhoea and Enteritis, 1. Other deaths under 1 year, 21. Other deaths over 1 year, 207. Stillbirths, 17. Total, 245.

Rural—Cancer, 27; Measles, 1; Pneumonia, Lobar (490), 2; Pneumonia (other forms), 9; Tuberculosis, 5; Whooping Cough, 1; Diarrhoea and Enteritis, 3. Other deaths under 1 year, 13. Other deaths over 1 year, 156. Stillbirths, 11. Total, 180.

Indians—Influenza, 1; Pneumonia of newborn, 1; Tuberculosis, 1. Other deaths under 1 year, 4. Other deaths over 1 year, 2. Stillbirths, 1. Total, 7.

*As reported to date.

Anterior Poliomyelitis should be over for 1951. Total, 47 cases, including four deaths.

Diphtheria—Only five cases. Almost too good to be true!

Scarlet Fever—1,230 cases—plenty but mild.

Tuberculosis—Still declining steadily.

Gonorrhoea, down a little, but.

Syphilis, down one-third and only one-quarter the number we had five years ago.

The all over picture is not bad.



GLYCURRANT



For the Relief of Persistent Coughs

A combination of effective sedatives and expectorants in a delicious preparation of Black-currant juice.

GLYCURRANT overcomes the difficulty of allaying persistent cough without resorting to respiratory depressants in large doses. It combines stimulating expectorants and respiratory sedatives of established efficiency, skilfully combined to relieve the chest, in a vehicle specially designed to exert its soothing local action on the irritated structures of the throat.

EACH FLUID OUNCE CONTAINS

Codeine Phosphate.....	gr. $\frac{1}{3}$	Menthol	gr. $\frac{1}{20}$
Syrup Wild Cherry.....	min. 40	Tincture Squill.....	min. 40
Glycerin	min. 80	Tolu	min. 40
Black Currant Juice	min. 165	Alcohol	5 percent

Dosage: Adults 1 to 3 teaspoonfuls undiluted should be sipped slowly every 3 or 4 hours. The size of the dose and the frequency of administration are varied at the physician's discretion.

Supplied in bottles of 16 oz., 80 oz., and 160 oz.

Department of Health and Public Welfare

Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1951		1950		Total	
	Dec. 2 to Dec. 29, '51	Nov. 4 to Dec. 1, '51	Dec. 3 to Dec. 30, '50	Nov. 5 to Dec. 2, '50	Jan. 1 to Dec. 29, '51	Jan. 1 to Dec. 30, '50
Anterior Poliomyelitis	2	11	0	1	49	17
Chickenpox	241	196	220	234	1777	1730
Diphtheria	1	0	1	0	6	17
Diarrhoea and Enteritis, under 1 yr.	10	6	7	6	155	148
Diphtheria Carriers	0	0	0	0	1	3
Dysentery—Amoebic	0	0	0	0	0	2
Dysentery—Bacillary	0	1	0	0	25	128
Erysipelas	2	3	2	2	32	49
Encephalitis	0	0	0	0	4	2
Influenza	8	4	11	3	784	174
Measles	100	99	319	128	3038	1674
Measles—German	2	3	1	0	46	36
Meningococcal Meningitis	1	1	0	0	35	17
Mumps	192	124	155	144	1509	691
Ophthalmia Neonatorum	2	0	0	1	4	3
Pneumonia—Lobar	15	12	22	26	253	249
Puerperal Fever	0	0	0	0	1	4
Scarlet Fever	69	110	44	66	1299	461
Septic Sore Throat	5	10	3	1	42	51
Smallpox	0	0	0	0	0	0
Tetanus	0	0	0	0	1	2
Trachoma	0	0	0	0	0	1
Tuberculosis	70	90	0	56	954	956
Typhoid Fever	2	0	0	0	5	4
Typhoid Paratyphoid	0	0	0	0	0	1
Typhoid Carriers	0	0	0	0	0	2
Undulant Fever	1	0	1	0	10	32
Whooping Cough	59	107	83	88	574	538
Gonorrhoea	98	109	99	94	1259	1317
Syphilis	11	11	12	21	156	227
Leukemia	0	0	0	0	0	5

Four-Week Period December 2nd to December 29th, 1951

DISEASES	*771,815 Manitoba	*861,000 Saskatchewan	*3,825,000 Ontario	*2,952,000 Minnesota
(White Cases Only)				
Approximate population.				
Anterior Poliomyelitis	2	1	9	49
Chickenpox	241	360	2327	---
Diarrhoea & Enteritis, under 1 year	10	1	---	---
Diphtheria	1	1	2	5
Diphtheria Carriers	---	---	---	---
Dysentery—Amoebic	---	---	---	5
Dysentery—Bacillary	---	3	---	18
Encephalitis Epidemica	---	1	---	---
Erysipelas	2	1	1	---
Influenza	8	7	---	6
Measles	100	89	591	87
German Measles	2	100	130	---
Leukemia	---	---	---	---
Meningitis Meningococcal	1	1	11	7
Mumps	192	236	1176	---
Ophthal. Neonat.	2	---	---	---
Pneumonia, Lobar	15	---	---	---
Puerperal Fever	---	---	---	---
Scarlet Fever	69	185	166	82
Septic Sore Throat	5	47	1	20
Smallpox	---	---	---	---
Tetanus	---	---	---	---
Trachoma	---	---	---	---
Tuberculosis	---	---	---	3
Typhoid Fever	70	30	86	182
Typh. Para-Typhoid	2	---	3	---
Typhoid Carrier	---	1	---	---
Undulant Fever	1	---	1	---
Whooping Cough	59	74	128	11
Gonorrhoea	98	---	170	---
Syphilis	11	---	31	---

*DEATHS FROM REPORTABLE DISEASES

For the Month of December, 1951

Urban—Cancer, 49; Influenza, 1; Pneumonia, Lobar (490), 1; Pneumonia (other forms, 491-493), 8; Pneumonia of newborn (763), 1; Poliomyelitis, 1; Syphilis, 1; Tuberculosis, 5; Hydatid disease (125), 1; Benign neoplasms (210-229), 1; Diarrhoea and Enteritis under 2 years (571.0), 2; Diarrhoea of newborn (764), 1. Other deaths under 1 year, 16. Other deaths over 1 year, 224. Stillbirths, 8. Total, 248.

Rural—Cancer, 38; Influenza, 1; Pneumonia, Lobar (490), 5; Pneumonia (other forms 491-493), 11; Pneumonia of newborn (763), 2; Syphilis, 1; Tuberculosis, 11; Whooping Cough, 3; Diarrhoea and Enteritis under 2 years (571.0), 1. Other deaths under 1 year, 22. Other deaths over 1 year, 201. Stillbirths, 16. Total, 239.

Indians—Measles, 1; Pneumonia (491-493, other forms), 2; Whooping Cough, 1; Diarrhoea and Enteritis (under 2 years, 571.0), 2. Other deaths under 1 year, 1. Other deaths over 1 year, 2. Stillbirths, 1. Total, 4.

This report gives the preliminary figures for the year 1951. On the whole Manitoba has been fortunate.

Chickenpox, Measles, Mumps and Scarlet Fever have been more prevalent than usual but fortunately they have not caused many deaths.

The killing diseases have been less in numbers:

Diphtheria—Six cases and none of these died.

Dysentery—Much less.

Influenza—Not well reported and there were no doubt thousands of cases but the disease was mild.

Tuberculosis—The number of cases about equal to 1950, the deaths are less.

Typhoid Fever—No deaths, five cases, three Treaty Indians.

Venereal Disease—Syphilis greatly reduced.

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